# ACCESS TO HEALTH INSURANCE

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

## COMMITTEE ON WAYS AND MEANS
## HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

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HARTFORD, CONNECTICUT, FEBRUARY 25, 1991

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**Serial 102-6**

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# ACCESS TO HEALTH INSURANCE

MONDAY, FEBRUARY 25, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 10:05 a.m., Old Senate Chamber, State Capitol, 210 Capitol Avenue, Hartford, Conn., Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, FEBRUARY 6, 1991

PRESS RELEASE #1
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

# THE HONORABLE PETE STARK (D., CALIF.) CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A FIELD HEARING IN HARTFORD, CONNECTICUT, ON ACCESS TO HEALTH INSURANCE

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The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a field hearing on access to health insurance. The hearing will be held on Monday, February 25, 1991, beginning at 10:00 a.m., in the Old Senate Chamber of the State Capitol, 210 Capitol Avenue, Hartford, Connecticut.

In announcing the hearing Chairman Stark said: "The signs of stress in the health care system are increasingly evident. Corporations complain that health insurance premiums are rising twenty to forty percent each year. Small businesses increasingly report that they are faced with astronomical cost increases, or selected employees are denied coverage due to chronic health problems. The people who need coverage the most end up without it, and the number of uninsured continues to climb. Connecticut is attempting to find solutions to these problems, and we need to assess the potential of those solutions for the nation as a whole."

Oral testimony will be heard from <u>invited witnesses only</u>. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

<u>BACKGROUND</u>

Thirty-three million Americans currently lack health insurance. As many as sixty-five million lack health insurance for at least thirty days during any two-year period.

One of the surprising statistics about the uninsured is that two-thirds are members of families with at least one full-time worker, while another ten percent are in families with a part-time worker.

The problem of lack of health insurance is particularly acute for employees of small business. Over 62 percent of workers in firms with fewer than 25 employees do not obtain health insurance from their own jobs, while only 14.6 percent of workers in firms with 1,000 employees or more do not obtain such coverage. There are almost seven million uninsured workers in firms with fewer than 25 employees, out of 14.4 million uninsured workers.

Health care costs appear to be rising faster for small groups than for large ones. A survey by the National Association of Manufacturers found that 1988 health care costs for firms with fewer than 25 employees rose 33 percent--a rate one and one-half times as high as the rate for large firms.

Various practices of the insurance industry appear to increase the problems faced by small groups in purchasing health insurance.

(MORE)

The wide use of experience rating to set premiums, as opposed to community rating, often raises insurance prices for small business. Other underwriting practices that negatively impact small businesses include exclusions of pre-existing conditions, large rate increases for firms with older workers or dependents who have the misfortune to contract a serious illness, segregation of high risk workers from group rates, coverage denials, and refusals to renew insurance.

Connecticut is in the process of implementing legislation enacted in 1990 which attempts to increase coverage for small groups and for low-income populations through a variety of reforms.

The Connecticut legislation includes: (1) establishment of standards of behavior for small group carriers, including requirements that all applicants be covered and rules for determining rates; (2) creation of a small employer health reinsurance pool; (3) provision of a special health care plan for previously uninsured groups; and (4) expanded public programs for low-income residents.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, March 11, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. The Health Subcommittee of the Committee on Ways and Means has never been honored with such a packed hall that included so few lobbyists and so many genuinely interested people, and it is a real tribute to your Congresswomen that you are here this morning.

I am doing the best I can, ma'am. I am shouting as loud as I can into this microphone, and it—normally, I would say it is a Republican sound system and that is why you cannot hear me, but I am sure that is not the case.

I am Pete Stark, and I am the chairman of the subcommittee, and I would like to say a few opening words, if I may. You all know my colleagues, Congresswoman Johnson from the Sixth Congressional District, and Congresswoman Kennelly from the First Congressional District, but you may not have the pleasure of knowing Congressman Brian Donnelly from the great city of Boston in the Commonwealth of Massachusetts, who is our ranking Democrat member here today, and Congressman Sander Levin from Detroit, Mich., and Congressman Bill Coyne from Pittsburgh.

We are all most interested in being here. Hartford is one of the few cities in the United States where hospitals are doing better than banks, and we have come to observe that. They are closing more banks than hospitals, and that is indeed a reverse on what we have seen.

Corporations are complaining that their health insurance premiums are rising 20 to 40 percent annually. Small businesses tell us that they face tremendous increases in their costs of health insurance as employees are denied coverage and chronic health problems are sending the costs through the roof.

People who need coverage the most end up without it, and the number of uninsured people keeps rising.

Connecticut, to its credit, is attempting to find a solution to the problem of the growing number of citizens without the financial protection that health insurance provides, and the Connecticut program focuses particularly on the problems of small businesses in purchasing health insurance at a fair price. This is certainly appropriate given the current situation in the market.

I am not going to dwell on the number of people without insurance; you are going to hear more about that today.

It is my understanding that the Connecticut approach rests on four steps: the creation of a reinsurance pool for small employers, restrictions on underwriting of small employer groups, development of low-cost insurance products for the small employer, and expansion of Medicaid eligibility and expansion of direct service programs for the lower-income population. These are all worthy approaches which need to be explored, and I appreciate the leadership of this State in that regard.

We will be watching with interest the implementation of this program, and I know our witnesses today will educate us about the details of this important initiative.

I would be less than direct, however, if I did not indicate some of my personal skepticism on whether this program will have more than a marginal impact on the problem of the 33 million Americans without health insurance.

I am not convinced that piecemeal approaches relying on the private sector can achieve our common goal of universal coverage. There are many problems with people who change jobs frequently and with the sharing of costs of dependent coverage when there are two employed family members. Also, many States are complaining about financing the current level of Medicaid benefits, much less having to find State money to expand those benefits.

I am concerned about relying on private sector approaches to contain costs and expand access at the same time. I am convinced that meaningful cost containment is beyond the capability of the private sector alone to achieve.

In my view, the public sector is better able to achieve these goals. The evidence, of course, is the Medicare program. While private sector costs are rising more than 10 percent per year in real dollars, Medicare's costs have been increasing 3 percent a year in real terms, and before our insurance witnesses report that Medicare's success is solely the result of cost shifting, let me suggest that their higher increases are completely due to the private sector's failure to achieve any cost containment.

In a zero sum game, when you lower one person's costs you obviously raise somebody else's. But the experience with all-payer rate regulation programs at the State level clearly shows that costs can be contained when payments by all payers are controlled or when there is only a single payer.

The failure of the health care system to contain costs does not take away from one payer, Medicare, which has been having success. At the same time the critical need to assure health insurance protection for every American demands our best efforts.

The impasse has been going on for far too long. I hope today's discussion will provide new insight into resolving this dilemma.

[The opening statement of Mr. Stark follows:]

THE HONORABLE PETE STARK
CHAIRMAN, SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS

HEARING ON ACCESS TO HEALTH INSURANCE

Hartford, Connecticut
February 25, 1991

The signs of stress in health care are increasingly evident.

Corporations complain that health insurance premiums are rising twenty to forty percent each year. Small businesses report that they face astronomical increases or selected employees are denied coverage due to chronic health problems.

The people who need coverage the most end up without it, and the number of uninsured keeps increasing.

Connecticut is attempting to find solutions to the problem of the growing number of Americans without the financial protection of health insurance.

The Connecticut program focuses particularly on the problems of small business in purchasing health insurance at a fair price. This is certainly appropriate given the current situation in this market.

Half of the working uninsured are employees of small firms. If we are to assure health coverage for all Americans, small firms are going to have to shoulder this burden, just as do most large employers currently.

Only forty percent of workers in firms with under 25 employees or less receive health insurance from their own jobs, while almost 85 percent of workers in firms with 1000 employees or more obtain coverage through the workplace.

There are almost seven million uninsured workers in firms under 25 employees out of 14-plus million uninsured workers.

We cannot, however, expect small employers to provide insurance for their employees if they are not able to purchase coverage at a reasonable price.

Health care costs are rising faster for small groups than for large. A survey by the National Association of Manufacturers found that 1988 health care costs for firms with less than 25 employees rose 33 percent -- a rate one and a half times as high as the rate for large firms.

The Connecticut approach to this problem rests on four basic steps:

* Creation of a reinsurance pool for small employers;

* Restrictions on underwriting of small employer groups;

* Development of low-cost insurance products for

small employer with restrictions on provider reimbursement; and,

* Expansion of Medicaid eligibility and expansion of direct service programs for the low-income population.

These are all worthy approaches which need to be explored and I appreciate the leadership of this state in that regard. We will all be watching with interest the implementation of this program, and I know our witnesses today will educate us about the details of this important initiative.

I am skeptical, however, that this program will have more than a marginal impact on the problem of 33 million Americans without health insurance.

I am not convinced that piecemeal approaches based in the private sector will achieve our common goal of universal coverage.

There are simply too many problems with people who change jobs frequently and with equitable sharing of the costs of dependent coverage when more than one employer is involved.

Most problematic, too many states are complaining about financing the current level of Medicaid benefits, much less any expansions in the program.

I am particularly concerned about reliance on private sector approaches to the problem of containing costs while expanding access.

I am convinced that meaningful cost containment is beyond the capability of the private sector to achieve. In my view the public sector is far better able to achieve these goals.

The evidence for this is the Medicare program. While private sector costs are rising more than ten percent per year in real dollars, Medicare's costs have been increasing three percent per year in real terms.

Before our insurance witnesses report that Medicare's success is solely the result of cost shifting, let me suggest that the higher increases are completely due to the private sector's failure to achieve any meaningful cost containment.

The experience with all-payer rate regulation programs at the state level clearly show that costs can be contained when payments by all payers are controlled, or when there is a single payer. The failure to do so does not take away from the one payer, Medicare, which has been having success.

The critical need to assure health insurance protection for every American demands our best priority efforts. The impasse has been going on for far too long. I hope today's discussion will provide new insight into resolving this dilemma.

I am particularly pleased to be here in the district of my colleague Congresswoman Barbara Kennelly, a distinguished member of the Committee on Ways and Means, joined by another distinguished member of the Committee and the Subcommittee on Health, Congresswoman Nancy Johnson. I want to thank them both for their assistance in arranging this hearing.

Chairman STARK. I am particularly pleased to be in the district of my colleague, Congresswoman Barbara Kennelly, a distinguished member of our committee, and joined by another distinguished member of the committee and the Subcommittee on Health, Congresswoman Nancy Johnson. It is through their efforts that this hearing has come to pass this morning, and I would like to recognize Nancy Johnson at this point for any comments she might have. [Applause.]

Mrs. JOHNSON. Thank you, Mr. Chairman.

In deference to our very interesting panels that we have, I will not make opening remarks.

I just want to thank you for your willingness to work with us, to bring this hearing opportunity to Connecticut, and I particularly want to thank my colleagues from the Health Subcommittee who are here with us today. I appreciate very much your taking a day out of your busy district schedules to be with us in Hartford today.

Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Barbara, would you like to make some remarks?

Mrs. KENNELLY. Thank you, Mr. Stark. I really want to thank Mr. Stark and Mr. Donnelly and the other members who have taken the time to come, because a Monday is a very important day in your own districts. So, for you to leave your districts means a great deal to me.

Nancy did not have to come far, but Sandy and Bill and Brian and Pete Stark certainly did.

I want to also give credit where it is due, and that is to 1199, the Health Care Workers Union, who came to see me not once, not twice, but three times and said, Barbara, something has to be done about access to health care. They more or less gave me a message that we better have a hearing or they were not going to be too pleased about it. So, I thank them for their insistence because every time I asked Pete Stark for a date, I said I have to have it, 1199 insists that I have this hearing.

I apologize to those who are standing, and I notice there are some younger men and women in the audience. Maybe some of you could trade your seats and stand and maybe help some of those who are standing. You know who you are and it is hard to stand, but give up your seat. [Applause.]

[The prepared statement follows:]

THE HONORABLE BARBARA B. KENNELLY
MONDAY, FEBRUARY 25, 1991
SUBCOMMITTEE ON HEALTH HEARING
HARTFORD, CT

First, I want to thank Chairman Stark and the others on the subcommittee for coming to Hartford to listen to our story as both the Health Subcommittee and the full Ways and Means Committee embark on a series of hearings designed to look at possible solutions to the problems facing our health care system. So, Welcome!

There is a growing consensus that we have reached a crisis point in America when it comes to health care. We have 33-37 million Americans without health insurance, costs are out of control, hospitals are closing their doors and neither employers or employees can afford health insurance while insurers are facing unprecedented claims.

First, for those of you who are not familiar with the uninsured, let me spend a moment here talking about their demographics. The medically uninsured are generally not the elderly; they after all are covered by Medicare. And they are not poor; they generally qualify for Medicaid. Rather, a majority of those who lack insurance are workers or family members in households in which at least one person is employed. Seventy percent are in families where at least one person worked at least part-time. It is striking to note that almost ninety percent of the employed uninsured worked for employers who did not offer health insurance. Frankly, it is these facts that I find unconscionable in America in 1991--that even working Americans don't all have health insurance.

The bottom line which makes this problem so hard to deal with, is that nearly two-thirds of the uninsured lived in poverty or within 200 percent of the poverty level. This is not at all surprising given that the majority of uninsured workers are low wage earners who can not afford private insurance, but it is something that must be addressed.

Well, now we know the uninsured are generally the working poor, children and the uninsurables. Add to the access problem for these groups the problems of the under-insured, cost control, the inability of small business to purchase insurance and adequate provider reimbursement, and it is clear why there has been a cry for national health insurance.

Personally I think the time for action in this area is long over due. However, I want to caution everyone here in the room that this is an issue without a consensus. I suspect that will be clear as this day progresses, but this debate is a necessary and healthy one and will continue for some time.

As my colleagues on the Subcommittee

well know, Hartford is the insurance capital of the nation. Some 55,000 people are employed in the industry right here in CT, and a large marjority of them in Hartford. So aside from trying to assure that every American has a basic right to at least a minimum level of care, we care on a more basic level because the decisions we make in Washington in this area will effect jobs in this community.

On a broader level let me say that the insurance industry has a great deal of knowledge and expertise about the health care system, which means that the industry has both a duty and an obligation to be part of the solution. This is frankly one of the reasons I asked Mr. Stark to bring the Subcommittee to Hartford to hear about some of the innovative things the industry is doing here in Connecticut to address these very real problems.

Frankly, along the way we are all going to have to answer some very tough questions. Some of the toughest issues seem simple at first glance. Who should be covered? Everyone or just those not currently covered or adequately covered by private health insurance, Medicare or Medicaid?

Should a comprehensive solution include a role for employers? What about private insurers? What about the self-insured?

What kind of coverage should be mandated? Catastrophic? Comprehensive? Should we mandate coverage of certain types of care? While a catastrophic care requirement would protect families in the event of a major illness, it might do less to assure access to basic health care. Comprehensive care would provide such access but would drive up costs. Similarly, while it may be socially desirable to require certain types of care, well baby care, mental health benefits or invitro fertilization, for example, such decisions put the federal government in the role of essentially apportioning health care simply by the choices we make in terms of what is paid for and what is not.

Should we limit individual contributions, copayments and deductibles? While this might be desirable to protect the working poor, it would drastically increase costs, and some would argue utilization. Keep in mind that each of these decisions can drastically alter the solution as well as its cost. In addition, the federal budget deficit would appear to preclude the commitment of substantial new federal resources to health care at this time.

And finally, perhaps most contentious of all is the question of who pays? Let there be no doubt that someone must pay--there is no free lunch--or free health care for that matter. And, I would venture to guess that everyone here thinks they are paying right now.

So I thank you all for coming today. I look forward to your testimony. We are looking for ideas; experience and I am hopeful that you can provide some. Thank you Mr. Chairman.

Chairman STARK. Barbara, thank you.

Our first panel this morning——

Mrs. KENNELLY. Pete, not to leave, just to stand.

Chairman STARK. Barbara said not to leave, just to stand, and we might try to rotate every witness panel, and have some people stand and let the people who are standing be seated.

In an effort to proceed quickly this morning, we will use a timer up here. I am going to ask everybody to suspend their testimony when they hear the 5-minute bell.

We have printed copies of your testimony, and without objection, we will see that the entire printed testimony appears in the record. I know the members of the committee are going to want to question the witnesses, which I think will give the witnesses a chance to expand on their testimony.

So in the interest of moving along, I will ask that we limit our remarks to 5 minutes. Our first panel of witnesses consists of the Commissioner of Health of the State of Connecticut, Dr. Frederick G. Adams; the president of St. Francis/Mount Sinai Hospital, Dr. David D'Eramo; the president of New Britain General Hospital, Mr. Larry Tanner; the executive director of the Charter Oak Terrace-Rice Heights Health Center, Ms. Alfreda Turner; and the president of Hartford Hospital, John Meehan. We will hear first from Dr. Adams.

Doctor, please start. You may proceed in any manner you are comfortable.

## STATEMENT OF FREDERICK G. ADAMS, D.D.S., COMMISSIONER, CONNECTICUT DEPARTMENT OF HEALTH SERVICES

Dr. ADAMS. Thank you, Honorable Chairman Stark and members of the Subcommittee on Health.

I will certainly speak rapidly so I can get as much——

Chairman STARK. I find that you almost have to swallow these microphones for people to hear you in the back. So if we would all watch that, it would help.

Dr. ADAMS. Having long been active in health care access issues at the local, State, and Federal levels, and because of my direct involvement with the recently enacted Connecticut insurance initiatives, I am pleased to be able to testify before you on this critical matter facing many of Connecticut's citizens, the estimated 275,000 uninsured.

I believe that ultimately, the Federal Government must provide policy leadership and take responsibility for developing a national health policy which will assure access to health care for all Americans. Please notice I said "national health policy," not "national health insurance." We do need a policy which assures universal access, building on the existing strengths of our system.

However, I will speak today primarily from the State perspective, taking as a foundation Public Act 90-134, passed by Connecticut's General Assembly last year.

This act sets in motion a series of private-public partnership actions to increase access to health insurance. Small group market reform, Medicaid improvements, including presumptive eligibility determinations for pregnant women, improved funding for commu-

nity health centers, and a proposal to develop a nongroup insurance product for pregnant women and for children who are all part of this legislation. The legislation also created a Health Care Access Commission to oversee implementation and develop further recommendations for the longer term, and it set a broad policy direction that Connecticut will "work to create the means to assure access to a single standard of care for all residents on an equitable financing basis and with effective costs controls."

We must make progress toward universal access, meaning that a single standard of care be available and accessible to all Connecticut residents regardless of economic status, race, ethnicity, creed, sexual preference, disability, or preexisting condition. Single standard of care means that the State and Federal Government must identify, endorse, and implement quality standards for all citizens.

Equity of financing, also stated as a goal in the legislation, means that all payers must operate under the same rules within the constraints and advantages of our pluralistic market system.

In order to achieve cost controls and get more out of our dollar, we believe that improvements in financing and insurance coverage should build on the existing health care infrastructure, but should also move us toward a new model of health care delivery.

A model which emphasizes cost-effective preventive services and primary care, rather than emphasizing costly secondary and tertiary care.

A model which provides a single point of entry for all rather than a sometimes overwhelming multitude of fragmented services.

A model which focuses on the health of individuals as members of families and communities, and on the outreach and community coalition building necessary to impact health outcomes rather than a system which looks at the individual in isolation.

A model which includes an emphasis of primary care providers, physicians, nurses, dentists, nurse midwives, nurse practitioners, physicians assistants and other such primary care providers, rather than the current overemphasis on high-technology and subspecialty practitioners.

A model which incorporates coordination and continuity of care rather than the present, often-episodic, approach.

A model which is organized to provide appropriate care in the most effective setting and manner for those with special needs, such as persons with hypertension, diabetes, and other chronic care needs. Persons with physical and mental disabilities, persons with occupationally related injuries, persons with care needs resulting from AIDS/HIV infection.

And a model which has a frame of reference, the capacity-building of the individual, family and community, as partners in the diagnostic, therapeutic and health maintenance process, rather than all too often emphasis on the provider as sole decisionmaker.

In Connecticut, we have embarked on a path which sets clear priorities. Improve Medicaid, develop affordable insurance policy for small businesses, and develop special public-private cooperative approaches.

In closing, I would like to encourage the Ways and Means Committee to continue to help Connecticut develop a delivery system that will in fact provide a new model of care which emphasizes pri-

mary and prevention services, recognizing that prevention is not only primary prevention, avoidance of disease, but also secondary prevention; early diagnosis and prophylactic treatment when needed, and tertiary prevention, including rehabilitation.

We also encourage you to continue to develop financing arrangements that will do more for pregnant women and children and will help strengthen the primary care network of community health centers and other community-based providers of care that we so desperately need.

Thank you very much for allowing me this 5 minutes of quick dialog.

[The prepared statement follows:]

TESTIMONY OF FREDERICK G. ADAMS, D.D.S., M.P.H
COMMISSIONER
CONNECTICUT DEPARTMENT OF HEALTH SERVICES
BEFORE THE HOUSE WAYS AND MEANS SUBCOMMITTEE
HEARING ON ACCESS TO HEALTH INSURANCE
HARTFORD, CONNECTICUT
FEBRUARY 25, 1991

HONORABLE CHAIRMAN STARK, MEMBERS OF THE SUBCOMMITTEE ON HEALTH:

HAVING LONG BEEN ACTIVE IN HEALTH CARE ACCESS ISSUES AT THE LOCAL, STATE, AND FEDERAL LEVELS, AND BECAUSE OF MY DIRECT INVOLVEMENT WITH THE RECENTLY ENACTED CONNECTICUT INSURANCE INITIATIVES, I AM PLEASED TO BE ABLE TO TESTIFY BEFORE YOU ON THIS CRITICAL MATTER FACING MANY OF CONNECTICUT'S CITIZENS - THE ESTIMATED 275,000 UNINSURED.

I BELIEVE THAT ULTIMATELY, THE FEDERAL GOVERNMENT MUST PROVIDE POLICY LEADERSHIP AND TAKE RESPONSIBILITY FOR DEVELOPING A NATIONAL HEALTH POLICY WHICH WILL ASSURE ACCESS TO HEALTH CARE FOR ALL AMERICANS. PLEASE NOTICE THAT I SAID "NATIONAL HEALTH POLICY," NOT "NATIONAL HEALTH INSURANCE." WE DO NEED A POLICY WHICH ASSURES UNIVERSAL ACCESS, BUILDING ON THE EXISTING STRENGTHS OF OUR SYSTEM.

HOWEVER, I WILL SPEAK TODAY PRIMARILY FROM A STATE PERSPECTIVE, TAKING AS A FOUNDATION PUBLIC ACT 90-134 PASSED BY CONNECTICUT'S GENERAL ASSEMBLY LAST YEAR.

THIS ACT SET IN MOTION A SERIES OF PRIVATE/PUBLIC PARTNERSHIP ACTIONS TO INCREASE ACCESS TO HEALTH INSURANCE. SMALL GROUP MARKET REFORM, MEDICAID IMPROVEMENTS, INCLUDING PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANT WOMEN, IMPROVED FUNDING FOR COMMUNITY HEALTH CENTERS, AND A PROPOSAL TO DEVELOP A NON-GROUP INSURANCE PRODUCT FOR PREGNANT WOMEN AND FOR CHILDREN WERE ALL PART OF THIS LEGISLATION. THE LEGISLATION ALSO CREATED A HEALTH CARE ACCESS COMMISSION TO OVERSEE IMPLEMENTATION AND DEVELOP FURTHER RECOMMENDATIONS FOR THE LONGER TERM, AND IT SET A BROAD POLICY DIRECTION - THAT CONNECTICUT WILL "WORK TO CREATE THE MEANS TO ASSURE ACCESS TO A SINGLE STANDARD OF CARE FOR ALL RESIDENTS.....ON AN EQUITABLE FINANCING BASIS AND WITH EFFECTIVE COST CONTROLS." THIS POLICY IS IN RESPONSE TO A BASIC CONCERN: WE NEED TO GET MORE FOR OUR HEALTH CARE DOLLAR, AND WE NEED TO MAKE A GREATER IMPACT ON HEALTH STATUS. WE ARE NOW SPENDING SOMEWHERE AROUND EIGHT BILLION DOLLARS OR MORE FOR HEALTH CARE IN CONNECTICUT, YET AS WAS MADE CLEAR IN THE HEARINGS HELD AROUND THE STATE BY OUR BLUE RIBBON COMMISSION ON HEALTH INSURANCE, INDIVIDUALS OFTEN ARE FACED WITH OVERWHELMING BARRIERS TO OBTAINING EVEN BASIC LEVELS OF HEALTH CARE. WE STILL DON'T HAVE SUFFICIENT ACCESS TO PRENATAL CARE, WE STILL DON'T HAVE A HANDLE ON HEALTH OUTCOMES, OR COSTS.

WE MUST MAKE PROGRESS TOWARDS UNIVERSAL ACCESS - MEANING THAT A SINGLE STANDARD OF CARE BE AVAILABLE AND ACCESSIBLE TO ALL CONNECTICUT RESIDENTS, REGARDLESS OF ECONOMIC STATUS, RACE, ETHNICITY, CREED, SEXUAL PREFERENCE, DISABILITY, OR PRE-EXISTING CONDITION. SINGLE STANDARD OF CARE MEANS THAT THE STATE AND FEDERAL GOVERNMENT MUST IDENTIFY, ENDORSE AND IMPLEMENT QUALITY STANDARDS FOR <u>ALL</u> CITIZENS. EQUITY OF FINANCING, ALSO STATED AS A GOAL IN THE LEGISLATION, MEANS THAT ALL PAYORS MUST OPERATE UNDER THE SAME RULES, WITHIN THE CONSTRAINTS AND ADVANTAGES OF OUR PLURALISTIC, MARKET SYSTEM.

IN ORDER TO ACHIEVE COST CONTROLS AND GET MORE FOR OUR DOLLAR, WE BELIEVE THAT IMPROVEMENTS IN FINANCING AND INSURANCE COVERAGE SHOULD BUILD ON THE EXISTING HEALTH CARE INFRASTRUCTURE, BUT SHOULD ALSO MOVE US TOWARD <u>A NEW MODEL OF HEALTH CARE DELIVERY</u>:

- A MODEL WHICH EMPHASIZES COST EFFECTIVE PREVENTIVE SERVICES AND PRIMARY CARE, RATHER THAN EMPHASIZING COSTLY SECONDARY AND TERTIARY CARE;

- A MODEL WHICH PROVIDES A SINGLE POINT OF ENTRY FOR ALL, RATHER THAN A SOMETIMES OVERWHELMING MULTITUDE OF FRAGMENTED SERVICES;

- A MODEL WHICH FOCUSES ON THE HEALTH OF INDIVIDUALS AS MEMBERS OF FAMILIES AND COMMUNITIES, AND ON THE OUTREACH AND COMMUNITY COALITION BUILDING NECESSARY TO IMPACT HEALTH OUTCOMES, RATHER THAN A SYSTEM WHICH LOOKS AT THE INDIVIDUAL IN ISOLATION;

- A MODEL WHICH INCLUDES AN EMPHASIS ON PRIMARY CARE PROVIDERS - PHYSICIANS, DENTISTS, NURSE MIDWIVES, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS AND OTHER SUCH PRIMARY CARE PROVIDERS, RATHER THAN THE CURRENT OVEREMPHASIS ON HIGH TECHNOLOGY AND SUBSPECIALTY PRACTITIONERS;

- A MODEL WHICH INCORPORATES COORDINATION AND CONTINUITY OF CARE RATHER THAN THE PRESENT OFTEN EPISODIC APPROACH;

- A MODEL WHICH IS ORGANIZED TO PROVIDE APPROPRIATE CARE IN THE MOST COST EFFECTIVE SETTING AND MANNER FOR THOSE WITH SPECIAL NEEDS SUCH AS PERSONS WITH HYPERTENSION, DIABETES AND OTHER CHRONIC CARE NEEDS, PERSONS WITH PHYSICAL AND MENTAL DISABILITIES, PERSONS WITH OCCUPATIONALLY RELATED INJURIES, PERSONS WITH CARE NEEDS RESULTING FROM AIDS/HIV INFECTION; AND

- A MODEL WHICH HAS AS A FRAME OF REFERENCE THE CAPACITY BUILDING OF THE INDIVIDUAL, FAMILY AND COMMUNITY AS PARTNERS IN THE DIAGNOSTIC, THERAPEUTIC AND HEALTH MAINTENANCE PROCESS, RATHER THAN AN ALL TOO OFTEN EMPHASIS ON THE PROVIDER AS SOLE DECISION MAKER.

IN CONNECTICUT, WE HAVE EMBARKED ON A PATH WHICH SETS CLEAR PRIORITIES: IMPROVE MEDICAID, DEVELOP AFFORDABLE INSURANCE POLICIES FOR SMALL BUSINESSES, AND DEVELOP SPECIAL PUBLIC-PRIVATE COOPERATIVE APPROACHES FOR OUR HIGHEST PRIORITY POPULATION - PREGNANT WOMEN AND CHILDREN. WE ARE WORKING TO DEVELOP AN APPROACH FOR THIS POPULATION (NOT ELIGIBLE FOR MEDICAID BUT NOT ABLE TO AFFORD PRIVATE INSURANCE), THAT WILL BUILD ON THE EXISTING INSURANCE STRUCTURE, BUT WILL INCLUDE CONSIDERABLE STATE SUBSIDY. WE DO NOT YET KNOW HOW THIS WILL WORK OUT IN DETAIL, BUT THE CONNECTICUT HEALTH CARE ACCESS COMMISSION, WITH THE ASSISTANCE OF THE DEPARTMENT OF HEALTH SERVICES IS WORKING HARD TO DEVELOP THE ADMINISTRATIVE, ACTUARIAL AND FINANCING SPECIFICS TO PRESENT TO THE LEGISLATURE.

IN ADDITION, BOTH NATIONAL AND STATE SUPPORT MUST BE INCREASED TO FOSTER THE DEVELOPMENT OF COMMUNITY BASED PRIMARY CARE NETWORKS, ESPECIALLY BUILDING ON THE EXISTING CAPACITY OF COMMUNITY HEALTH CENTERS, LOCAL HEALTH DEPARTMENTS, AND OTHER PRIMARY CARE PROVIDERS. PROGRAMS SUCH AS THE HARTFORD ACTION PLAN ON INFANT HEALTH, ASSISTED BY THE SUPERB INVOLVEMENT OF REPRESENTATIVE BARBARA B. KENNELLY OF THE WAYS AND MEANS COMMITTEE, MUST ALSO BE PART OF THE SOLUTION. THESE DELIVERY SYSTEM "INFRASTRUCTURE" ELEMENTS ARE CRITICALLY IMPORTANT, AS FINANCING ALONE DOES NOT ASSURE ACCESS 100%.

IN CLOSING, I WOULD LIKE TO ENCOURAGE THE WAYS AND MEANS SUBCOMMITTEE TO CONTINUE TO HELP CONNECTICUT DEVELOP A DELIVERY SYSTEM THAT WILL IN FACT PROVIDE A NEW MODEL OF CARE WHICH EMPHASIZES PRIMARY AND PREVENTIVE SERVICES - RECOGNIZING THAT PREVENTION IS NOT ONLY PRIMARY PREVENTION (AVOIDANCE OF DISEASE), BUT ALSO SECONDARY PREVENTION (EARLY DIAGNOSIS AND PROPHYLACTIC TREATMENT WHEN NEEDED), AND TERTIARY PREVENTION, INCLUDING REHABILITATION. WE ALSO ENCOURAGE YOU TO CONTINUE TO DEVELOP FINANCING ARRANGEMENTS THAT WILL DO MORE FOR PREGNANT WOMEN AND CHILDREN, AND WILL HELP STRENGTHEN THE PRIMARY CARE NETWORK OF COMMUNITY HEALTH CENTERS AND OTHER COMMUNITY BASED PROVIDERS OF CARE THAT WE SO DESPARATELY NEED. THANK YOU VERY MUCH FOR ALLOWING ME TO TESTIFY. I WILL BE GLAD TO RESPOND TO ANY QUESTIONS.

Chairman STARK. You are not done yet, doctor. We will be back to you in just a moment.

Dr. D'Eramo.

**STATEMENT OF DAVID D'ERAMO, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, ST. FRANCIS HOSPITAL AND MEDICAL CENTER AND MOUNT SINAI HOSPITAL, HARTFORD, CONN.**

Mr. D'ERAMO. Mr. Chairman and members of the committee, I, too, am pleased to have this opportunity to be with you today to speak about access to health care. Ours is a health care system that offers the best care in the world to those who can afford it. Yet, we recognize that the system is seriously flawed and denies access to great numbers of Americans.

Because ours is such a diverse country and we lack a national model, the health care situation differs by State. We can obtain an idea of the spectrum of approaches by comparing California and Connecticut. The approach in California might be characterized as a legislatively mandated open market for health care, which requires competition.

Connecticut, at the opposite end of the spectrum, if you will, is close to having a legislatively mandated closed market.

Overall, the Connecticut approach has worked well. Our conservative regulatory approach has restrained costs. The State's statistics compare well with U.S. averages. On the negative side, it must be admitted that the conservative approach has left the State with aging facilities and equipment.

Hospitals in Connecticut also have a problem of inadequate reimbursement for Medicare and Medicaid patients. One of the institutions I am representing today, Mount Sinai Hospital, is in danger of closing in significant part due to this problem.

Medicare and Medicaid were created to produce access to health care. The premise was that reasonable costs would be paid for services. However, benefits were added and programs and beneficiaries expanded while the principle of reasonable cost reimbursement has eroded greatly over the past decade. Access to health care for Medicaid and Medicare recipients now is purchased at the expense of private payers who make up for the underpayment. At Mount Sinai, the proportion of Medicaid and Medicare patients as compared to the rest of the commercial payers became too skewed for the hospital size. The cost shift to commercial payers to make up for the governmental deficit caused prices to increase.

As a consequence, private pay price increases produced by governmental underpayment have become prohibitive. This is an access issue because that hospital serves a large part of the Greater Hartford community. If it is forced to close, access becomes much more difficult for a community that often uses Mount Sinai in place of a family physician.

In time, I would submit, underfunding of governmental programs affects all consumers by threatening access to quality care.

The access problem in Connecticut is somewhat unique. The State established a Blue Ribbon Commission to develop a proposal for a comprehensive and universal State health insurance program as well as to address uncompensated care in the State's hospitals.

Connecticut, with affluent suburbs and impoverished populations in inner cities, has a challenge in serving both of these populations equitably. The legislature has attempted to create a new model for health insurance that will expand Medicaid benefits to the very poor and create health insurance benefits for the near poor. Also, the Connecticut solution amended insurance laws so that commercial insurers could create different policies for some segments of society, particularly small businesses. We view this law as a promising beginning, and we look forward to working with our governmental representatives in fine-tuning and implementing it.

The root of the problem of providing access to health care insurance in Connecticut and in the Nation as a whole is our changed approach to the risk pool. The Nation's health insurance system originally was based on pooled risk. That is the way insurance usually works. A large group of insureds, all of whom are at some risk, operate so that those not experiencing risk support the others, but in the area of health insurance, members of the risk pool began to be segregated and the principle was destroyed.

When the commercial insurance companies joined Blue Cross and the health insurance market in the fifties, normal business prudence dictated that they assume the better risk or those less costly to insure. As this seemingly rational process evolved, the market and the risk pools were segmented.

Now, we have essentially six different risk pools. We have Medicare, Medicaid, indemnity insurers, managed care, the self-insured, and the uninsured. This sets up a natural dynamic in which the payers for each group attempt to minimize their own costs, often at the expense of the other groups.

Government programs designed to provide insurance for the poor and aged segments of the population have passed much of the costs of providing this health care to more affluent consumers, businesses, and the Nation's hospitals. These groups understandably are no longer willing to or cannot afford to pay for the costs of Government programs.

We have a lack of national unity. The real issue is how do you bring the country back together. We need a constructive method that relies to some extent on market forces and to some extent on regulatory forces.

Finally, we need to determine if you can impose a national system over a country that is as broad and diverse as the United States.

Any solutions to the health care crisis are going to need to look at multiple factors: One, what constitutes basic services, two, what is the funding mechanism for these service, and three, what are public and private responsibilities.

The United States principally allows market forces to work. However, reliance on market forces in vital industries can create major problems, and we have seen that with deregulation. Deregulation of health care seems quite risky in light of such experience. This needs to be considered in fashioning a health care system that provides basic health care for all Americans.

I thank you.

[The prepared statement follows:]

Testimony of David D'Eramo, Ph.D.

President and Chief Executive Officer
Saint Francis Hospital and Medical Center, Hartford, Connecticut
and Mount Sinai Hospital, Hartford, Connecticut.
Given before the Subcommittee on Health of the House Ways and Means Committee on February 25, 1991, Hartford, Connecticut.

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**Mr. Chairman and Members of the Committee:**

I am pleased to have this opportunity to be with you today to speak about access to health care.

Ours is a health care system that offers the best care in the world to those who can afford it. Yet we recognize that the system is seriously flawed and denies access to great numbers of Americans.

Because ours is such a diverse country and we lack a national model, the health care situation differs by state. We can obtain an idea of the spectrum of approaches by comparing California and Connecticut. The approach in California might be characterized as a legislatively-mandated open market for health care, which requires competition. Connecticut, at the opposite end of the spectrum, is close to having a legislatively-mandated closed market.

Overall, the Connecticut approach has worked well. Our conservative regulatory approach has restrained costs. The State's statistics compare well with U.S. averages. Just to give you some idea of this comparison, let me cite some averages per thousand of population: **beds** - Connecticut 3.04, national average 3.84; **admissions** - Connecticut 111, compared with a national average of 128; **inpatient days** - Connecticut 851, national average 926; **surgical operations** - Connecticut 84, national average 88; **outpatient visits** - Connecticut 1272, compared with 1174, and finally, **hospital expense per capita as a percent of per capita personal income** - Connecticut 5.2 percent, compared with 6.4 percent.

On the negative side, it must be admitted that the conservative approach has left the state with aging facilities and equipment.

Hospitals in Connecticut also have a problem of inadequate reimbursement for Medicaid patients. One of the institutions I am representing today, Mount Sinai Hospital, was in danger of closing in significant part due to this problem.

Medicare and Medicaid were created to produce access to health care. The premise was that reasonable costs would be paid for services. However, benefits were added and programs and beneficiaries expanded, while the principle of reasonable cost reimbursement has eroded greatly over the past decade. Access to health care for Medicaid and Medicare recipients now is purchased at the expense of private payers, who make up for the underpayment.

At Mount Sinai, the proportion of Medicaid and Medicare patients as compared to the rest of the commercial payers became too skewed for the Hospital's size. The cost shift to commercial payers to make up for the governmental deficit caused prices to increase. As a consequence, private pay price increases produced by governmental underpayment have become prohibitive.

This is an access issue because that hospital serves a large part of the Greater Hartford community. If it is forced to close, access becomes much more difficult for a community that often uses Mount Sinai in place of a family physician. In time, underfunding of governmental programs affects all consumers by threatening access to quality care.

The access problem in Connecticut is somewhat unique. The state established a Blue Ribbon Commission to develop a proposal for a comprehensive and universal state health insurance program, as well as address uncompensated care in the state's hospitals. The Commission came up with some interesting information. They found 272,000 people, or one out of every ten persons under 65, in Connecticut lacking in health insurance. Approximately 27 percent of this group had incomes below the poverty level for a

family of four, but a large number (44 percent) had incomes in excess of $36,000 a year. The Commission also found that the proportion of the Connecticut population without insurance is among the lowest of any state. Two-thirds of the adults without health insurance are employed, and over one-third is employed full time. These statistics may be dated, based on the slowing economy in the state, but they do indicate that the Connecticut legislation is designed to directly address the needs of the residents of this state. Connecticut, with affluent suburbs and impoverished populations in inner cities, has a challenge in serving both of these populations equitably.

The legislature has attempted to create a new model for health insurance that will expand Medicaid benefits to the very poor and creates health insurance benefits for the near poor. Also, the Connecticut solution amended insurance laws so that commercial insurers could create different policies for some segments of society, particularly small businesses. It permits policies to be narrower so that some benefits are eliminated, and thus the policy costs less. It also requires hospitals to take care of policyholders at 75 percent of the Medicare rate. In effect, therefore, it is a discount to a discount, and hospitals end up providing care that once again is not reimbursed at the level of its cost.

Nonetheless, we view this law as a solid beginning, and we look forward to working with our governmental representatives in fine tuning and implementing it.

The root of the problem of providing access to health care insurance in Connecticut - and in the nation as a whole - is our changed approach to the risk pool. The nation's health insurance system originally was based on pooled risk. That's the way insurance usually works. A large group of insured, all of whom are at some risk, operates so that those not experiencing risk support the others.

But in the area of health insurance, members of the risk pool began to be segregated, and the principle was destroyed. When the commercial insurance companies joined Blue Cross in the health insurance market in the 1950s, normal business prudence dictated that they assume the better risks, or those less costly to insure. As this seemingly rational process evolved, the market and the risk pools were segmented.

Now, we have essentially six different risk pools: Medicare (100 percent federal), Medicaid (federal/state), indemnity insurers, managed care, the self-insured, and the uninsured. This sets up a natural dynamic in which the payers for each group attempt to minimize their own costs, often at the expense of the other groups. Government programs designed to provide insurance for the poor and aged segments of the population have passed much of the cost of providing this health care to more affluent consumers, businesses, and the nation's hospitals. These groups understandably are no longer willing to or cannot afford to pay for the costs of the government programs.

We have a lack of national unity. The real issue is how do you bring the country back together? We need a constructive method that relies to some extent on market forces and to some extent on regulatory forces. Finally, we need to determine if you can impose a national system over a country that is as broad and diverse as the United States.

Any solutions to the health care crisis are going to need to look at multiple factors:

1. What constitutes basic services
2. What is the funding mechanism for these services
3. What are the public and private responsibilities

The U.S. principally allows market forces to work. However, reliance on market forces in vital industries can create major problems. Deregulation of banking and air transportation, of telephone service and other utility-like industries has not been a panacea. Deregulation of health care seems quite risky in light of such experience. This needs to be considered in fashioning a health care system that provides basic health care for all Americans.

Americans may not be as amenable to socialized medicine as Canadians. Canadian society is European in its reliance on central authoritative ministries for health, education, and social issues. It is dubious whether this approach is readily exportable to the U.S.

We also need to remember that while primary care is freely available to all Canadians, patients needing cardiac and other hospital services are frequently sent to the U.S. for diagnosis and treatment because of Canada's long hospital queue. Again, we find a system that does not offer a panacea.

Thank you.

Chairman STARK. Thank you, doctor.
Mr. Tanner.

**STATEMENT OF LAURENCE A. TANNER, PRESIDENT, NEW BRITAIN GENERAL HOSPITAL, NEW BRITAIN, CONN.**

Mr. TANNER. Thank you very much, Mr. Chairman.

Chairman STARK. I guess you have to use this one microphone. It is the only one that is hooked up to the PA system.

Mr. TANNER. Thank you very much.

I appreciate the opportunity to speak before the subcommittee today.

We all share a concern on the alarming rate of increase in the cost of health care. As an employer of approximately 2,500 people, I am aghast to see my premiums increase on the average of 20 to 40 percent per year.

I believe that the early attempts at controlling the costs of health care failed, and I think partly it is a function of the change in the delivery patterns of care, and it is a change in the expectations of the population.

Managed care, HMOs, PPOs, and the new delivery systems, I believe, will work, but they will need time and they will need the support on the National and State levels.

However, many of these changes are being thwarted by a series of events. Foremost, at least in our State, is Government underpayment. The second is the——

Chairman STARK. Government underpayment?

Mr. TANNER. Underpayments.

Chairman STARK. That is what I thought you said.

Mr. TANNER. Yes. The second is the significant cost shift to both the individual and to the employer. The third is an impact of new technology. In our community, we introduced a magnetic resonance imaging scanner last year. The revenues generated by that equipment approximated $2.5 million, yet these are $2.5 million of new dollars going into the health care field.

New drugs are also a problem. We saw the introduction of a much safer contrast media for x rays that increased costs for our hospital from approximately $50,000 to nearly $1 million in 1 year. Epogen, a wonderful drug, a safe drug, for patients on dialysis, added $600,000 of expense to New Britain General last year, and, last of all, is a much greater concern, which is the profit motive in medicine.

I do not believe personally that the free market works in medicine, and, yet, we are seeing ever increasing numbers of providers entering into the field for profit. Individuals who share today not only in doing the procedure but in owning the equipment and owning the corporation and leasing the land or the building.

Access in Connecticut has been a bit unusual. We have an adequate number of physicians, albeit maybe not enough primary care physicians, but we certainly do not have the issues of 2 to 3 hours of travel between an individual to find a doctor.

Our willingness, though, on the part of all of our providers, our physicians, to take all patients who seek care in their offices,

though, is in fact becoming a problem. Our facilities, on the other hand, are rather unique.

We have no for-profit hospitals in our State. No one is turned away from a hospital in the State of Connecticut. In fact, we have many mandated requirements to take all who come before our doors. We have a high population density in our State, and, therefore, the distance that one travels for health care is in fact limited, and although we are one of the rare States to be regulated, it is my personal belief that this is a plus rather than a negative.

However, access is limited by a number of factors. As was mentioned earlier, we have the costs being shifted to the individual, and in today's economy with the recession biting hard in our State, the ability of the individual to pay between 20 to 30 percent of their health care stay at a hospital oftentimes in the $1,500 to $2,000 range is prohibitive.

We have also seen that our insurers in our State are beginning to recognize their financial difficulties and are beginning to limit their risks. They are going to continue to discontinue small groups. They are dropping companies unless individuals who have high health care utilization sign waivers for their members of the family, and also they are dropping people because of previous illness.

We are very concerned that in these next few years, the Government must do things. It must do them quickly. We need a national health policy. We must eliminate the cost shift. We must combine the Federal programs in health care delivery, and we must simplify the bureaucracy, and we must eliminate the profit motive from the delivery system.

I thank you for the opportunity to speak before the subcommittee.

[The prepared statement follows:]

STATEMENT OF LAURENCE A. TANNER
PRESIDENT OF NEW BRITAIN GENERAL HOSPITAL
NEW BRITAIN, CONNECTICUT

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BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON WAYS AND MEANS
FEBRUARY 25, 1991 - HARTFORD, CONNECTICUT

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Chairman Stark and members of the Subcommittee on Health of the Committee on Ways and Means, I would like to thank you for the opportunity to participate in this hearing on the issue of access to health insurance and health care. As the chief executive officer of a 400-bed, community teaching hospital, my knowledge on the subject is limited to my 20 years of experience as a health care professional delivering health services at the community level. Although I have seen much change in the delivery of health services over these past two decades, the rate of change occurring in the last four to five years far surpasses the previous periods, and I expect it will be considered slow to the changes that will occur in the remaining years of this decade.

As the crisis on the cost of health care grew in magnitude and severity, employers, government and other providers of insurance became alarmed. Early attempts at controlling utilization, such as hospital-based utilization review committees, did little to stem the tide of increasing costs. External utilization review, second opinion before surgery and other similar attempts at controlling the technology and services--be it inpatient or outpatient--were bowled over by the magnitude of cost increases. At the same time that utilization was being controlled, new technology, new drugs and the aging of the population were putting pressure on the cost escalation problem.

Managed care, I believe, has been and will be a more effective tool of controlling costs than anything we have seen to date. Yet, in many parts of the country, managed care covers under 15 percent of nongovernment patients. A lack of control in most areas of the country on certificate or determination of need for the construction of new or replacement facilities and/or technology has offset attempts at utilization management. This increase in the availability of technology, coupled with defensive medicine and approval of the use of very expensive pharmaceutical agents has worsened the problem. An ever-growing older population adds to the burden of health care utilization, and new diseases such as AIDS and the concurrent measures needed to insure infection control and waste management have added to the cost.

The increasing cost of health care driven by technology, patient-care management, and the reimbursement system with an increasing impact of cost shifting due to government underpayment, has reached the point where employers and the other payors of care were forced to take drastic action. The impact of the changes on providers, such as hospitals, has been significant, but the real victim has become the private citizen. As employers saw year-after-year increases in premiums of between 30 to 50 percent, they were forced to make changes to their health care plans. Co-payments and deductibles by workers, which were restricted to some five to ten percent of the Fortune Five Hundred Companies ten years ago, have now been almost universally implemented. It is not unknown today to see plans with 20 percent co-payment, costing an employee $1,600 out-of-pocket for a hospital stay. For the large employer with a critical mass of employees, the cost shifting to the employee, which oftentimes includes a reduction in benefits for spouses and dependents, has not resulted in a decrease in cost. For the medium-sized to smaller employer, even with this shift of the burden for payment to the individual, the increase in cost for health care coverage demanded even greater attention. The smaller employer began to offer a more limited health care plan, not covering such things as mental health, prior disease, or certain tertiary services. Other small employers were forced to exclude certain employees in order to get health insurance at a reasonable cost, and yet for others the only alternative was to drop health care coverage for all their employees. This is indeed a national problem which requires national solutions. Yet, we in Connecticut, in central Connecticut, and specifically in the city of New Britain are a microcosm of the national experience.

What we as providers are concerned about is the issue of access to care. In our view, a barrier to access to care is the result of one of several

factors. Not necessarily in rank order, the following are major constraints that have to be evaluated.

First is the issue of geographic access. In parts of the southwest, midwest and south, it is not uncommon for an individual to have to drive hours for care, even at the physician level. Subspecialty care is not available in one's community and requires additional travel, lost time from work, etc. Although Connecticut has rural pockets, because of its high population density, it is rare for any citizen to live greater than a half hour from an acute care hospital with an emergency room staffed 24 hours a day. Although we do not have a perfect distribution of primary care specialists and all subspecialists are not represented on every hospital's staff, once again the distribution is sufficient so that it is rare to have citizens beyond easy reach of an internist, family practitioner or pediatrician. I should add, however, that geographic proximity does not necessarily assure access as we have found in several inner city locations, including our own in New Britain. All physicians do not necessarily accept all insurances, and several will not take state or city welfare patients, thereby creating an access problem for care if the majority of physicians within a specialty in a particular geographic area are not participating physicians.

The issue of which physicians and why practitioners accept particular patients is a second concern for access to health care. Because of the reimbursement levels, reporting requirements, and the tendency for a lower level of cooperation between the patient and the physician, state and city welfare patients are finding it exceedingly difficult to gain access to the private physician's office. This has placed a greater burden on the remaining physicians in the community who are willing to treat city and state welfare patients and on the clinics of hospitals, primarily those in inner city locations with teaching programs. This is particularly difficult in obstetrics. There is an increasing number of young pregnant women in the inner cities delivering who have had inadequate health care throughout their pregnancies, resulting in an increase in infant mortality and morbidity.

Just last week a newspaper headline appeared about the New Haven community, the home of two of our largest hospitals and a nationally prestigious medical school, that highlighted the fact that New Haven had the highest level of infant mortality of any community over 100,000 in the United States. Hartford, the home of the insurance industry and in one of the highest geographic income areas of our country, followed behind New Haven in infant mortality. Although not one and two in the country, the Hartford and New Haven communities represent a dichotomy of wealth and education mixed with poverty and an inadequate number of physicians willing to practice in inner city areas.

Therefore, even though we might not have to drive for hours to find a primary physician, because of the reimbursement system and other problems, welfare recipients may not have access to a primary physician within their community. New Britain General Hospital was recently approached by a social service agency in a community about a half an hour from it. That particular community has a hospital, although smaller than ours. The social service agency indicated that they represent clients who, on average, deliver approximately 150 babies per year. There are no physicians in that area who are willing to contract to cover these patients, the majority of whom are either city or state welfare clients. Those patients drive by that hospital to come and deliver at New Britain General Hospital. While that hospital itself has a maternity program and it is willing to take all who come seeking care, the physicians were not willing to take on this extra social burden.

This leads us to a third factor which could limit access to care--access to institutional providers. Connecticut is unusual in many regards. We have an excellent system of health care, including a full spectrum of pre-hospital, acute, tertiary care, and a wide realm of outpatient and support facilities. We have two excellent rehabilitation hospitals and a strong network of skilled, intermediate and rest care facilities. We are not under served as a state in terms of the numbers of physicians and the distribution of specialties. We are an attractive state for physicians in many ways because of the wealth of the residents, availability of excellent hospitals in which to practice and a myriad of social and recreational activities in which to participate. We are the home of a number of fine private and public universities, and as a whole have excellent primary and secondary schools.

We have no proprietary hospitals, no charity hospitals and no city hospitals. The hospitals in our state tend to be significantly larger than those found in many other parts of the country, and the services provided are enhanced because of research in drugs and technology often conducted by the medical staffs of the two fine medical schools located within our state. For a state our size, we have a disproportionate number of teaching hospitals, primarily as a result of our physical location within the northeast corridor. Hospitals are relatively close together because of the population density of the central and southern core of our state.

Access to acute and emergency care is guaranteed by regulations developed by the Health Department which require each hospital to provide emergency care and appropriate triage. Unlike many states, we have had, for nearly 20 years, a strong regulatory presence requiring certificate of need for major capital expenditure and the introduction of new technology. Therefore, we do not have the evils of the free market system in health care with open heart, MRIs, CT scanners, etc. on every street corner. This certificate-of-need process regulates not only hospitals but the introduction of major technology by private groups and has regulatory authority on rate setting. Therefore, the ability for investor-owner entities to reap unregulated profits is a much more difficult task in our Connecticut than in much of the rest of the country.

The hospitals in this state have not in the past nor will they in the future discriminate against any patient because of the source of payment. You can walk into any hospital room in any of the 36 Connecticut hospitals, and you cannot, without looking at a patient's financial data, tell whether that patient is a city, state, Medicare, indemnity or managed care patient. Although the government passed laws recently establishing penalties for "dumping of patients," the law was not intended to correct a problem in Connecticut. A patient seeking care in an emergency room in this state is accepted regardless of the source of payment, or if payment is to be received at all. Patients admitted to Connecticut hospitals are treated by members of the medical staff, even if that physician would not see the patient in his private office as a non-Medicaid or welfare participating physician. We have had a long tradition of access to our institutions.

The problem we are seeing today is not one of access; it is one of an increasing burden created by patients seeking care in the hospital because they cannot find a physician or are embarrassed to seek care in the private sector because they lack insurance or because they belong to a group with social and cultural needs that has not traditionally developed a private patient-physician relationship.

Of greatest concern to those of us who manage hospitals is this geometric growth in patients presenting to the hospital who are now under- or who are totally uninsured. Putting aside the financial burden to the institution, of greater concern is the delay by individuals to seek care, many of whom are proud and do not wish "charity." Patients are coming to our doors later in the disease process than they should, and then they require longer recuperative processes with greater expense for medication, technology, etc. In the remaining part of my presentation, I will address this last issue of access to health coverage in more detail--the issue of access hampered by the lack of health insurance.

In publication after publication we read that on a national level between 30 to 40 million citizens of this country are without health insurance. In a recent study conducted by Connecticut's General Assembly, it was reported that 270,000 people, representing 10 percent of the non-elderly population, are without insurance. Many of the uninsured are low income. Approximately 25 percent have incomes below 150 percent of the poverty level, while at the same time over 40 percent have incomes over 300 percent of the poverty level. One-quarter of the uninsured were children, with nearly 10 percent under the age of six. In terms of racial background, nearly 20 percent of the Hispanic residents of our state are uninsured, nearly twice the level of non-Hispanics. Ten percent of blacks are uninsured compared to eight percent of whites.

Another interesting finding was that two-thirds of the uninsured adults in Connecticut are employed, and of this number 33 percent are working full-time. In addition to the quarter of a million residents who lack any health insurance, an additional 140,000 people are underinsured. The underinsurance covers such categories as lack of catastrophic care, lack of coverage because of

insurance exclusions due to prior illness or a submarginal insurance package, and lastly a lack of supplemental coverage for Medicare recipients because of the inability to buy the supplemental insurances for physician coverage, outpatient services, etc.

In terms of age, Connecticut has a population that is older than the country as a whole, and New Britain residents are older than the state average. According to numbers released as part of the 1990 census, nearly 18 percent of the New Britain area population is over the age of 65, and of that total over 7 percent are over 75. This is an 18 percent increase in area citizens over the age of 65 compared to the 1980 census. In terms of race, over 18 percent of the population in the New Britain area are nonwhite--an 86 percent increase in the nonwhite population since the 1980 census. Hispanics have gone from approximately 8.8 percent of the population in 1980 to over 16 percent in 1990. As the population of the towns in our service area continues to age dramatically and shifts from white to nonwhite, we see an ever-increasing pattern of patients seeking care at our hospital who are both uninsured and underinsured.

The numbers of un- and underinsured are swelled by changes in the demographics of our work force and the economic clime. Once known as the ball bearing capital of our country, the bearing industry has all but disappeared from central Connecticut. The city of New Britain's employment some 15 year ago was centered in eight large manufacturering corporations, producing bearings, home products, appliances, springs and hardware. Over the last decade, the big eight has become the big one, with only The Stanley Works remaining. Six of the large manufacturers have closed their doors or reduced employment to the level of small job shops. The seventh recently relocated its operations out of the city, leaving The Stanley Works as the only major manufacturer in the community.

Unfortunately, during this last decade the hospital rose from ninth largest employer to second largest employer, behind Stanley Works, in terms of the number of full-time equivalent employees on the payroll. Although the number of employed individuals in the community has remained fairly constant, the large employers with established broad-based, fully paid health benefits were replaced by companies with limited plans heavily dependent upon employee contributions. As many of the medium-sized firms downsized and as start up replacement industries employed under 30 people, the health insurance picture has become progressively worse.

The impact upon the financial condition of the hospital has been rather startling. In 1985 approximately four and one-half percent of our discharges were patients classified as self pay. In our most recent fiscal year, the percentage of discharges allocated to the self-pay patient category had risen to nearly 7 percent. Medicare patients increased from 28 to nearly 30 percent of our discharges. During this same six-year period, state and city welfare patients went from 7 percent to over 10 percent of our discharges.

The impact on the outpatient area was even more startling. From 1986 to the present, clinic visits rose from 41,000 to over 65,000. Visits to the emergency room increased from 39,000 to nearly 46,000. Ambulatory surgery visits increased from slightly over 4,000 to nearly 6,500. Private referred visits for laboratory, x-ray, etc. increased from 41,000 to 62,000 visits. Visits to our psychiatric outpatient services increased by nearly 100%.

The negative financial impact has even been greater than the increase in activities. Bad debts net of recoveries at New Britain General Hospital have increased 1.6 million to 5.2 million dollars over the last five years. Days in receivables at the hospital have increased over this same time frame from approximately 65 to 112 days. Contractual allowances have increased from approximately 2 million dollars in fiscal year 1986 to over 24 and a half million dollars in 1990, due primarily to shortfalls in payments from the federal government, state and city welfare sources. Accounts receivable also increased from 12 million to nearly 29 million dollars.

To accommodate increases in activity in our clinics and outpatient departments, coupled with the demands placed on social work and patient accounts, we have had to add nearly 50 employees during the past three years. Although I cannot certify that each of these employees was added as a direct result of increases in under- and uninsured patients, there is no question that the vast majority of additional hours added resulted from increases in direct service, reporting, and related support activities.

As we have seen the economy in central Connecticut continue to erode; as we have seen large businesses shrink and leave the community to be replaced by smaller employers; and as we have seen the rolls of state and city welfare patients increase, the most tragic impact has been on the individual patient. Our social workers tell stories of companies who were forced, because of premium increases, to get specific employees to sign waivers of noncoverage so that the rest of the workers in the company would have health insurance affordable to the employer. The insurance companies providing indemnity plans for small groups are becoming more and more selective, dropping group after group with no alternative for insurance. Premium increases to small groups are averaging 40 to 50 percent per year--increases simply not tolerable to employers who, because of the economic conditions of our state, are barely able to keep their doors open. We have had numerous patients tell stories of having their group insurance dropped and having exclusion after exclusion offered by other potential insurers, if insurance is available to them at all. We have had patients who came to the emergency room who have said that they simply could not afford health insurance and, therefore, waited to seek care only as a last resort.

We have seen other providers of care require up front payment for office visits. We have seen families go through their meager savings in order to pay us and their physicians for needed health care because their employers no longer provide health insurance. We have seen more and more patients going to our clinics and emergency room seeking care with the hope that it will be for free because their employer never provided them with health insurance. The current recession has exacerbated the problem, but rest assured the problem has been growing each year during this last half decade.

With rising bad debts and contractual allowances, the hospital has increased working capital borrowings, adding three-quarters of a million dollars of expense for interest payments alone. We have seen a deteriorating operating margin, culminating in a loss of over six million dollars in the last fiscal year.

As you will hear in later testimony, the state of Connecticut, though legislation, has taken a first step in developing a program that provides health care for the small employer. Although we as hospitals will only be paid approximately two-thirds of the already inadequate Medicare rate, this plan will provide insurance for some that was previously unavailable.

It is my belief that this is but the first in a series of steps which must be taken, not only at the state level but at the national level to solve our problem. Through a combination of tax incentives, small businesses must be given the encouragement to provide health insurance for their workers and dependents. These programs, coupled with expanded government programs for the unemployed, should provide all individuals in this country with access to at least basic health care services. The delivery and financing arrangements provided though employer and governmental contributions will insure the effective management of medical conditions, appropriate coordination of care among providers, and insure the maintenance of quality care.

The new systems must work towards the elimination of cost shifting so that private financing will bear the true cost of services provided. Incentives must be put in place so that care is provided efficiently. Care must be provided at the community level, encouraging the users of health care to seek care in efficient settings in a timely manner. Rather than having a multitude of public assistance programs, such as Medicare, Medicaid, Aid to Dependent Children, and other state and city welfare programs, there should be a single coordinated governmental health care financing plan. To insure that there is no over capacity generated by new dollars pumped into the health care system, each state should establish a strong certificate-of-need program to review the introduction of new facilities, technology and major plant renovation. This regulatory process should extend to the setting of rates to insure that the delivery of health care by corporate medicine is not done at an unduly high cost. The fraud and abuse provisions now being enacted to insure that patients are not steered for profit to a particular practitioner or setting must be expanded. With universal coverage, no provider should be allowed to not accept patients based on their payor source.

Changes in the delivery system require a new sense of responsibility on the part of the patient. Patients should, and in fact must, participate in the course of their treatment. Better yet, we must develop a national system to insure that prior to illness or injury each adult citizen is given the opportunity to establish the limits of care which they would

personally find acceptable should serious accident or disease strike. Better informed consumers who help practitioners establish the limits of care that they wish to receive can do nothing but improve the entire health care delivery system.

In conclusion, we, as a single hospital or as an association of hospitals, nor a single state can act alone. The 30 plus million citizens of our country that are underinsured need help. The burden cannot fall on employers alone. We turn to you to work with us in the establishment of a national health plan. Access to quality health care has become a right to all. We agree that the system as it is currently constituted is inefficient, costly and inadequate. The health of our nation rests with the health of our citizens. We can no longer afford to not develop a national health policy--the time is now.

Thank you again for the opportunity to speak before the Subcommittee on Health of the Committee on Ways and Means. I would be happy to answer any questions that you or members of your staff may wish to ask.

Chairman STARK. Thank you.
Ms. Turner.

**STATEMENT OF ALFREDA D. TURNER, M.P.H., EXECUTIVE DIRECTOR, CHARTER OAK TERRACE-RICE HEIGHTS HEALTH CENTER, HARTFORD, CONN.**

Ms. TURNER. Thank you, Mr. Chairman and committee members.

Five minutes is not long enough to tell you about the uninsured, the need for access to health care, and the devastating effect on lives for those who go without.

We know that access to health care is a complex, multifaceted problem that plagues our Nation. The distinction between access to health care and the availability of health care is depicted in the overwhelming number of physicians who will not accept Medicaid or uninsured clients.

There are many barriers to access. One of the problems that we face is recruitment for those of us who serve America's underserved. Basically, many physicians do not want to work in these areas because they make less money. They have to see heavier case loads of clients, and the clients have a multitude of health problems that are very complex and complicated.

Cultural sensitivity is another problem because most patients are black and Latino, who are low-income and uninsured, yet the providers often come from middle-class America, often Ivy League schools, and cannot relate to these populations. They do not understand the nutritional practices. They do not understand why there are high teenage pregnancy rates. They often do not understand why mothers are not in the waiting rooms cooing to their babies because those mothers are worried about where their next meal will come from or whether someone is going to identify or realize that there is a man in the household and funds be cut off.

They often do not understand why mothers are on AFDC instead of working, because if they work, they do not make enough money to pay for health care costs or for day care costs. Also, their Medicaid is lost once they become employed. Because of lack of training they become America's low-income uninsured.

I will say that many people offer these individuals the best that they have. They say do not fry your foods, broil them, do not eat chicken skin, it is not good for you. If they do not have a very culturally sensitive phased-in program of someone who understands why food is prepared the way that it is and support them through that change, the plan will fail.

Basically, Connecticut recognizes the need for a universal health insurance plan. They know that 84 percent of the uninsured are families where the head of household or the spouse is employed. Expansion of access to the uninsured has a serious cost equation if it is not properly addressed.

America is spending significantly on health care. The question is—is it spending wisely.

Basically, Dr. Louis Sullivan, Secretary of Health and Human Services, addressed the National Association of Community Health Centers in March of 1990, with a plan to assure access to health care for all. That plan was very simple—expand community health

centers from the existing 580 to just under 3,000 by the year 2000. That is an increase of 250 health centers a year.

Community health centers will see anyone who comes to their door, regardless of insurance coverage.

Second, they place themselves in locations to serve America's uninsured. Also, they have been statistically proven to provide high-quality cost-effective health care to these populations and they manage them well in a culturally sensitive environment.

The cost effectiveness of the community health center model has been studied over the years. The average cost of services per year are one-third lower than the national average for comparable services by other providers. Basically, there are 10 community health centers in the State of Connecticut, 6 of which receive Federal funding.

These centers provided 275,000 patient visits in 1988 to over 65,000 of Connecticut's underserved. In Hartford, there are two community health centers, Charter Oak Terrace-Rice Heights Health Center, where I am employed, and Community Health Services in the north end of the city.

In 1990, these two health centers provided for over 88,000 visits to Hartford residents, including the homeless. However, there is a problem at Charter Oak. Of the clients we served in fiscal year 1990, 98 percent had incomes below the Federal poverty level of $12,100 for a family of four.

In 1990 alone, uninsured clients rose from 16 to 26 percent, which is a 63-percent increase in 1 year. Demand is overwhelming.

I say thank you for allowing me to speak for the 37 million Americans who are underinsured and uninsured. Much needs to be done.

[The prepared statement follows:]

Testimony Concerning

"Access To Health Care and the Availability of Health Insurance"

Before the
Subcommittee on Health, Committee on Ways and Means
U.S. House of Representatives
February 25, 1991

Submitted by:
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CHAIRMAN OF THE SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, AND COMMITTEE MEMBERS.

Latest estimates are that 37 million Americans are uninsured! (This approximates the population of all of New England, plus New York state and half of Pennsylvania). Seventy-five percent are either employed or live in families where at least one person is employed. Many uninsured work for small firms, those with less than 25 employees, which nationally is the largest source of new jobs. Over 30% of the uninsured have family incomes below the federal poverty level ($12,100 for a family of four), but are still ineligible for Medicaid. Millions more have some limited insurance which does not cover necessary preventive health care and often has prohibitively expensive co-insurance payment requirements, which causes this group to have health statistics that are similar to those of the uninsured. Medicaid covers only 42% of America's poor while those accepting Medicaid as a form of payment is declining. This health problem is serious, headed for catastrophic. National and state intervention are a must.

Although big businesses are maintaining health insurance programs for their workers, evidence is mounting that they are streamlining benefit packages and are asking employees to share a larger percentage of the costs. As much as ninety-percent of businesses are expected to reduce coverage to employee dependents over the next decade.

Reductions in Medicaid eligibility levels during the Regan era has compounded the numbers of uninsured today. Almost 33% of all states nationally have Medicaid thresholds below the federal poverty level. Some estimate that as many as 40% of hospitals existing today will close by the year 2000 because of reduced reimbursement rates and the shifting of uninsured patients to public hospitals.

Access to health care is a complex, multi-faceted problem that plagues our nation on a state and local level. The distinction between access to health care and availability of health care are depicted in the overwhelming number of physicians who will not accept Medicaid or uninsured patients. In like point, hundreds of thousands of sick individuals go without health care annually until treatable condition's are truly life threatening.

Other barriers to access include the imbalanced ratio between numbers of primary care providers for underserved and uninsured populations and the millions who need these services, or in other words, the lack of providers in many areas of need. It is estimated that as many as 10 million Americans speak little or no English, which emphasizes the problems with language and cultural barriers.

Out-of-pocket costs, as well as the geographic barriers of distance to sites of care, impede access. Private practitioners study neighborhoods and locate their practices in and near well-insured and higher income areas.

These access barriers have been collectively recognized in federal designations of certain areas as Medically Underserved Areas (MUA's) and Health People Power Shortage Areas (HPPSA's).

Lack of access also causes many low income and uninsured to delay seeking care and to rely more on the episodic emergency room care versus the comprehensive community-based outpatient model that effectively tackles and reduces mortality and morbidity rates.

In December of 1989, Travelers Insurance Company published some statistics about uninsured populations. They found that employees are increasingly declining to pay out-of-pocket for dependent insurance plans to cover their children, opting rather to "take a chance" because the children are healthy. Of the uninsured under age 65, they found 33% children, 18% non-working adults, and 29% full-time/full-year workers. Thirty-four percent had family incomes under $10,000; 28% earned $10,000-$19,999; and 23% earned $30,000 or more. Thirty-two percent had incomes below 100% of poverty, while 29% fell between 100-200% of poverty (a total of 61% with family incomes of less than $24,200 for a family of four).

Much has been publicized about the percentage of the U.S. gross national product spent on health care, compared to other industrialized nations. Study after study recommends a national health insurance plan. America leads industrialized nation in health spending, but embarrassingly trails in health status indicators. Iceland's health spending is 61% of the total U.S. health care budget, but they have the lowest infant and child mortality rates. Finland spends 46% of the total U.S. health care budget, but is second lowest to Iceland for infant and child mortality. Many are looking at Canada's national health plan as one for a likely replication in the U.S.

Connecticut, along with a few other states, such as New Jersey, New York, and Oregon, is receiving national recognition for its proactive role in addressing problems of access to health care for the uninsured. In 1989, the Connecticut Blue Ribbon Commission on State Health Insurance was establish to develop a comprehensive and universal health insurance program for all persons in the state.

The problems of the uninsured in Connecticut were assessed with the assistance of a Washington, D.C. - based consulting firm, Lewin/ICF. The report of the Commission was issued in March of 1990. The Lewin/ICF study findings were:

* approximately 272,000 residents lack health insurance
* about 25% have incomes below 150% of poverty ($18,150 for a family of four)
* 43% have incomes above 300% of poverty ($36,300 for a family of four)
* the percentage of low-income uninsured is lower than many states because Connecticut has a broad eligibility Medicaid program plus a state funded General Assistance program, which complements the Medicaid program
* 25% of the uninsured are children
* Hispanics are almost twice as likely to be uninsured as non-Hispanics
* 10% of Blacks versus 8% Whites are uninsured
* 84% of the uninsured are in families where the head of household or spouse is employed
* 140,000 Connecticut residents are underinsured, having either insurance with limited coverage, Medicare coverage combined with low incomes, or are subject to risk because of underinsured catastrophic risk. An estimated 70 million insured Americans are at significant risk to catastrophic costs because of inadequate health insurance coverage.

National comparison data with insured populations reveal that the uninsured are less likely to have a usual source of care and, therefore, utilize hospital-based providers at higher rates. They also utilize fewer total health services and seek fewer preventive services than their insured counterparts. Aware of the need, uninsured groups also assess their personal health status to be lower than those with health insurance coverage.

The Blue Ribbon Commission agreed that appropriate, single standard, cost-efficient health care should be accessible to all Connecticut residents, regardless of their ability to pay. They recommended current insurance mechanisms be expanded and modified

to improve access to health care while a state universal access model is developed.

Expansion of access to the uninsured has a serious cost equation, if not properly addressed. If other industrialized nation's are providing better health care and have lower mortality and morbidity statistics for a significantly lower percentage of their gross national product, the U.S. and each state must assess the reasons. Health care spending in the U.S. has spiraled from 7.2% of the GNP in 1970 to 12% in 1988, and is projected to reach 20% by the year 2020. The U.S. spends 170% more per capita than the United Kingdom ($2,051 versus $758) yet fares no better in health statistics. This is at a time when Medicaid is serving only half the population in need, 40% of all hospital beds are empty nationally, and there is a trained physician for every 300 people. In Connecticut, hospital rates have soared with some hospitals requesting rate increases in 1990 of up to 42%. Uncompensated care costs are a factor.

In 1988, the U.S. spent 27% more on health care than any other nation. Overhead in the Canadian health insurance plan, Canadian Medicare, is less than 3%, which is about the same as the American Medicare and Medicaid plans, compared to 23 cents of every health care dollar spent on administrative costs in other health plans.

In 1970, both the U.S. and Canada spent 7.2% of their GNP on health care. In 1990 Canada spent 8.6% of its GNP on health care, which provides access to all residents, while the U.S. spent 12% and 37 million Americans have no health insurance coverage.

Just as the American public has expressed its preference for a national health insurance plan, Connecticut residents support a state universal health insurance plan. This plan must be accessible to all, affordable, comprehensive, quality-based and state administered.

Dr. Louis Sullivan, Secretary of Health and Human Services, addressed the National Association of Community Health Centers in March, 1990 with "A Plan to Assure Access to Health Care for All Americans." He described community and migrant health centers as a critical first step to a viable plan that will provide access to comprehensive health care.

Community health centers were started in 1965 through funding of eight pilot projects by the Office of Economic Opportunity. Three years later there were thirty centers in operation and four more underway. By the early 1980's, there were over 800 centers nationally. Today, 580 centers provide quality comprehensive services to almost six million people.

Community health centers believe that health care should be available to all, not only those who can afford to pay. Therefore, health centers strategically locate in areas that are accessible for the low income and uninsured. The health care model is based on social medicine and comprehensive primary care, while encouraging and fostering community involvement. Health centers have a consistent and documented record of providing high quality, cost effective health care to low income, hard-to-serve, high need populations.

Research findings indicate that minority and low income populations have poorer health status and higher mortality rates. African-Americans and Latinos are more likely to be in poverty. In the Northeast, White poverty rates are 9.5% compared to 33.2% for African-Americans and 37.7% for Latinos. Yet, of those in poverty in the Northeast, 71% are White, according to DHHS statistics. According to 1980 Connecticut census figures, 11.4% of all children in the state live in poverty. The African-American child poverty rate was 33.7%; the Latino child poverty rate was 43.4%. Newly released preliminary 1990 census figures show the City of Hartford had significant growth in its already predominant African-American and Latino populations.

Approximately 70% of patients seen at community health centers are minorities and most are low income and uninsured. Thirty-five percent are children. Many of the uninsured are also elderly, having high rates of malnutrition, mental illness, and substance abuse. Another uninsured group is the four million migrant farm workers, whose seasonal work often does not last long enough for them to meet state Medicaid residency requirements. Migrant Health

Centers are an integral part of the Community Health Center infrastructure, positioning themselves to meet the needs of this special group. Community/Migrant Health Centers have a statistically proven success at providing comprehensive primary health care, focusing on prevention and health education, providing culturally and linguistically sensitive services, and utilizing a case managed approach.

The cost effectiveness of the Community Health Center model has been studied over the years. Average cost of services per year are 1/3 lower than the national average for comparable services. At less than $200 per patient per year, dollars are well spent, considering CHC's have been proven in multiple national studies to:

* lower infant mortality rates
* reduce emergency room utilization
* have hospital admission rates at 50% of those who use hospital outpatients as their primary source of care
* reduce prevalence of infectious diseases
* intervene successfully with high need populations
* have higher immunization rates
* have higher rates of pap smears
* offer access to care and referral on a 24-hour per day, 7-day per week basis

Many have diagnostic and radiology services, which are provided on a more cost-effective basis; provide for emergency care for minor trauma; provide on-site pharmaceutical services; and even provide transportation for clients who would otherwise lack access.

Census figures for 1980 ranked Connecticut's three largest cities (Bridgeport, Hartford, and New Haven) among the ten poorest cities in the United States. Hartford is the poorest Connecticut city with 46% of its population having incomes below 185% of poverty.

There are ten community health centers in the state of Connecticut, six of which receive some federal funding. In 1988, these ten CHC's provided for more than 275,000 patient visits to over 65,000 of Connecticut's underserved. Seventy-five percent of clients were African-American or Latino. Access for clients served was fostered by location of facilities in areas of need; sliding scale fees that make adjustments for income, including those with no ability to pay; culturally sensitive and multilingual staff; outreach services, including home-based assessments; and continuity of care through assigning patients to their own physician as in a private practice model. Health Center physicians have admitting privileges at local hospitals and most often manage their own patients during hospital stays.

In Hartford, there are two community health centers, Charter Oak Terrace-Rice Heights Health Center and Community Health Services. Charter Oak Terrace-Rice Heights also operates a federally-funded Homeless Health Care Program in the City of Hartford. In 1990, the two health centers in Hartford provided for over 88,000 visits, including services to homeless clients.

At Charter Oak Terrace/Rice Heights, 98% of the clients served had incomes below the federal poverty level. In 1990, uninsured clients increased from 16% to 26%, a 63% increase in one year. At Community Health Services, 16% of their total clients for 1990 were uninsured, for a total uncompensated care cost of over $312,000.

Total patient visits to Charter Oak Terrce-Rice Heights Health Center in 1986 were 16,620. This number soared to the 20,000 mark in 1987. In 1988, the patient visit total was 27,402 including 6,515 visits for the first six months of our Homeless Health Care Program. The 1989 total was 34,945 including 15,063 for the Homeless Program. In 1990, total visits rose again to 37,560 (16,974 Homeless sub-total). New patients to the Health Center are averaging 11 per day, 200+ per month. Patients not new to the system are continuing to come for follow-up care. Medical appointments are booked three weeks in advance; dental is often booked six weeks in advance. A significant amount of additional space is critically needed. An analysis by external consultants revealed there is an increasing demand for health care services within the predominantly Latino and African-American Charter Oak

Terrace-Rice Heights housing projects in addition to the surrounding geographic service area.

Secretary Sullivan's Access 2,000 plan is one for providing health care to the remaining 30 million plus uninsured in America. This plan is direct-- an increase in community health centers nationwide from 580 to just under 3,000 by the year 2000. This would mean the establishment of 250 new centers per year over the decade. He estimated there are 500 existing non-federally-funded health clinics across the country, many of which would be appropriate for development into Community Health Centers.

In Hartford, Charter Oak Terrace-Rice Heights Health Center has state bond funding pending, which will allow them to more than double total capability for providing services, an imperative move since over 20,000 visits were provided to clients at the current primary site in less than 5,000 square feet of space. This expansion will also allow this health center to provide for diagnostic laboratory and radiology services on-site to a population without transportation and finances to adequately access these services at non-health center locations. Opthamology services will also be available on-site at the satellite facility for patients who currently have no referral resource in south Hartford for diagnosis and management of eye problems.

Community Health Services is completing an on-site expansion plan which has allowed them to double their care provision capability. An additional satellite may be necessary for them to ensure access to all north Hartford uninsured residents. Charter Oak Terrace-Rice Heights Health Center, Community Health Services and the Hartford Housing Authority are currently developing a collaborative plan for ensuring access to quality affordable health care for residents of all low and moderate income housing projects in the entire City of Hartford. This plan will probably require development of a center operated transportation system for Charter Oak Terrace-Rice Heights Health Center, as well as implementation of its planned satellite facility. Community Health Services will also probably need to establish a smaller satellite to ensure access for all.

Other community health centers in Connecticut have similar expansion plans also, based on growth trends and demand for services. Contacts have been made with the state primary care association director by representatives from six areas as of the state, requesting technical assistance in applying for federal start-up funds to develop community health center sites in their areas as a part of the national expansion. These plans for increased total community health centers in the state of Connecticut are in line with Secretary Sullivan's proposal.

The Lewin/ICF findings for the state of Connecticut's universal health insurance plan referenced the community health center model, suggesting health centers expand and that services by other providers mirror those required in the Community Health Center program. When amortized over time, start up costs for new health centers will pay for themselves in cost savings from improperly utilized hospital services.

Connecticut also has many other health provider models that are worthwhile. Hospitals and health centers have a symbiotic relationship that can be mutually cost beneficial if properly utilized. Community Health Services has coordinated its late evening hours of operation with Mt. Sinai Hospital for cost effective utilization. Charter Oak Terrace-Rice Heights Health Center is evaluating the need to expand evening hours. Discussions have started with Hartford Hospital, the south end secondary and tertiary care facility, regarding promotion of the cost effectiveness of our symbiotic relationship. Emphasis will be on fostering appropriate utilization of each facility, because each has seen a tremendous growth in demand for services and both realize that access to care and cost containment are a must for survival.

Other state programs to address health care for the uninsured include a Healthy Start Program, which makes health care available to pregnant women and their infants as a complement to the state Medicaid program. The Healthy Start Program covers children 0-12 months of age for families at 185% poverty who do not qualify for

Medicaid. In addition, the program covers children 12-18 months old whose family incomes are at or below 185% of poverty.

The state medicaid program is more comprehensive than in many other states. Pregnant women are covered, as well as childrlen 0-12 months of age at 185% of poverty. There is also a General Assistance Program for very low income individuals.

The Connecticut state legislature has taken a proactive role to ensure access to health care on a universal basis in spite of severe budgetary limitations and budget deficits. The 1990 General Assembly included a line item for Community Health Centers, allowing $500,000 for expansion of services to the uninsured. The newly encumbered Governor, Lowell P. Weicker, has recognized the continuing importance of community health centers in his 1991-92 budget proposal. Governor Weicker has proposed an increase in funding for that line item.

A national health insurance plan is needed, a state universal health plan is needed, an expansion of comprehensive primary care facilities on the one-stop health-care shopping model of community health centers is needed to address the compelling need for access.

Thank you very much for this opportunity to speak on access to health care for the uninsured.

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Chairman STARK. Thank you very much.
Mr. Meehan.

**STATEMENT OF JOHN MEEHAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HARTFORD HOSPITAL, HARTFORD, CONN.**

Mr. MEEHAN. Good morning, Mr. Chairman and members of the committee.

Hartford Hospital is a member of the Connecticut Health System, a three-hospital system that provides in-patient care for one out of every eight patients admitted to a hospital in Connecticut. The system is also one of the largest providers of out-patient services in the State.

Collectively, the CHS hospitals have large-scale and firsthand experience with the problems related to access to care and the financing of care for the uninsured and the underinsured in both urban and suburban settings.

I hope that our experience will be of use to you in your deliberations.

My comments are organized as follows: first, a brief summary of the financial and nonfinancial indicators of the magnitude of the problem. Second, a summary of the program initiatives that we are undertaking to address problems of access and financing, and, third, some suggestions that we would offer to the committee for additional inquiry in consideration.

First, with regard to indicators of the magnitude of the problem, our experience suggests that it is serious and getting worse. Bad debts at Hartford Hospital net of recoveries amounted to more than $16 million in 1990, and this amount as a percentage of total gross revenues has increased by more than 40 percent during the last 5 years.

However, the real impact of the uninsured care issue is evidenced in hospital emergency rooms and clinics. For example, we are located in the center of the city and provide care for more than 90,000 patients visiting our emergency room each year, 30 percent of whom are uninsured, a number that traditionally increases slightly each year.

We provide primary care in a number of clinics to more than 85,000 outpatients annually. Furthermore, we sponsor a community health clinic off our main site that provides care for the elderly in our immediate community.

As you can see, we provide a tremendous amount of care to this population, and we do the best that we can to provide this care with excellence. However, in too many instances, particularly for patients who seek primary care in an emergency room setting, the care is episodic rather than continuous.

Let me now mention a few of the initiatives that we as a system expect to help ameliorate the health care access problems of the uninsured.

During the past several years, we in Newington Children's Hospital have worked together to plan for the move of the existing suburban-based Newington Hospital to a site on our main hospital campus. This is a move that makes sense given the age of the pediatric facilities at both sites, and the opportunity to integrate the

pediatric services of Hartford and Newington Children's and thereby improve continuity of care.

This move will also increase tremendously the access for an urban population to specialized pediatric services that are provided only by Newington.

A significant part of the project is the intention to establish a special fund dedicated to the provision of primary care for the children of our city and the region. This fund is planned to be established through contributions from the endowment of Newington and contributions from other health care organizations and corporate benefactors. Thus, there is an intention to commit as a community significant funds to improve continuity and quality of care for patients many of whom are uninsured.

There is a third important program we have initiated that should help to address the problems of financing care for the uninsured. This initiative is called MedSpan. It is the first in the State of a provider-sponsored preferred-provider network in which hospitals and physicians participate with employers to design health care benefit packages with incentives to rationalize, not ration, the use of health care services.

In addition, MedSpan will be focusing its efforts on providing cost-effective health insurance coverage for small employers whose employees have historically been most at risk for the lack of insurance coverage.

Furthermore, through the use of a sophisticated data base to identify and correct inappropriate and excessive use of services and through higher coinsurance levels and higher deductibles, we believe that MedSpan will help us to achieve the goal that everyone has, improved access to and quality of patient care at costs that are acceptable to employers.

This brings me to the third and final section of my comments this morning, some suggestions for additional inquiry and consideration.

The financing of care for the uninsured demands an explicit health care policy choice. Hospitals obviously have an ethical obligation to provide appropriate care for those who seek it at their facilities. The greatest burden of the care of the uninsured in Connecticut falls to larger hospitals in urban areas with concentrations of people who, generally speaking, have lower per capita income and significantly greater health status problems.

I would emphasize at this point that the institutions in our system and in this State are not-for-profit organizations; that is, public trusts provide care, irrespective of the patient's ability to pay. Thus, once patients arrive at our emergency room, at our clinics, they have access to the full array of services provided by our institution.

At the same time, in fulfilling this obligations, we put our viability at risk. The fact is that providers who serve a proportionately large population of State and federally insured patients and uninsured patients, because of geographical location or limited geographic reach of clinical services, face a threatened future.

As has already been mentioned, partly as a result of this situation in our own city, Mount Sinai Hospital's status as an independent financially viable institution has been altered.

In conclusion, we know that the way the issue of the uninsured is resolved has far-reaching implications for access to care for these people, for the future financial health and viability of organizations that seek to address their needs, and for the costs of care for Government and industry.

We, therefore, support a collaborative effort involving Government, business, labor, insureds, and health care providers that explicitly addresses the ethical quality of care and economic issues related to the provision of care for the uninsured.

Thank you very much for this opportunity to share our experiences and views, and thank you for coming to the Connecticut area.

[The prepared statement follows:]

Hartford Hospital
Hartford, Connecticut

Testimony before the Health Subcommittee
of the Ways and Means Committee
Concerning Care for the Indigent

25 February 1991

Good morning Mr. Chairman and members of the Committee. I am John Meehan, President and Chief Executive Officer of the Hartford Hospital. Hartford Hospital is a member of the Connecticut Health System (CHS), a three-hospital system that provides inpatient care for one out of every eight patients admitted to a hospital in Connecticut, and the system is also one of the largest providers of outpatient services in the State. Collectively, the CHS hospitals have large scale and first hand experience with the problems related to access to care and the financing of care for the uninsured and the underinsured in both urban and suburban settings, and I hope that our experience will be of use to you in your deliberations.

My comments are organized as follows: 1) First, a brief summary of the financial and non-financial indicators of the magnitude of the problem, 2) Second, a summary of the program initiatives that our system is undertaking to address problems of access and financing; and 3) Third, some suggestions that we would offer to the Committee for additional inquiry and consideration.

First, with regard to indicators of the magnitude of the problem, our experience suggests that it is serious and it is getting worse. Bad debts at Hartford Hospital, net of recoveries, amounted to more than $16 million in 1990, and this amount, as a percentage of total gross revenues, has increased by more than forty percent during the last five years. However, the real impact of the uninsured care issue is evidenced in hospital emergency rooms and clinics. For example, the Hartford Hospital, located in the center of the City, provides care for more than 90,000 patients visiting our emergency room each year, thirty percent of whom are uninsured. We provide primary care in a number of clinics to more than 85,000 outpatients annually. Furthermore, we sponsor a community health clinic off our main site that provides care for the elderly in our immediate community. As you can see, we provide a tremendous amount of care to this population, and we do the best that we can to provide this care with excellence. However, in too many instances, particularly for patients who seek primary care in an emergency room setting, the care is episodic rather than continuous.

Let me now mention a few of the initiatives that we, as a system, expect to help ameliorate the health care access problems of the uninsured. During the past several years, Hartford Hospital and the Newington Childrens' Hospital have worked together to plan for the move of the existing suburban-based Newington Hospital to a site on our main hospital campus. This is a move that makes sense, given the age of the pediatrics facilities at both sites and the opportunity to integrate the pediatrics services of Hartford Hospital and Newington Childrens' Hospital and thereby improve continuity of care. This move will also increase tremendously the access, for an urban population, to specialized pediatrics services that are provided only by Newington Childrens' Hospital.

A significant part of the Newington project is the intention to establish a special fund dedicated to the provision of primary care for the children of our City and the region. This fund is planned to be established through contributions from the endowment of the Newington Childrens' Hospital and contributions from other health care organizations and corporate benefactors. Thus, there is an intention to commit, as a community, significant funds to improve continuity and quality of care for patients, many of whom are uninsured.

There is a third important program that we have initiated that should help to address the problems of financing care for

the uninsured. This initiative is called MedSpan. MedSpan is a provider-sponsored "preferred provider network" in which hospitals and physicians participate with employers to design health care benefits packages with incentives to rationalize -- not ration -- the use of health care services. In addition, MedSpan will be focusing its efforts on providing cost-effective health insurance coverage for small employers, whose employees have historically been most at risk for lack of insurance coverage. Furthermore, through the use of a sophisticated data base to identify and correct inappropriate and excessive use of services and through higher co-insurance levels and higher deductibles, we believe that MedSpan will help us to achieve the goal that everyone has: improved access to, and quality of, patient care, at costs that are acceptable to employers.

This brings me to the third and final section of my comments this morning: some suggestions for additional inquiry and consideration. The financing of care for the uninsured demands an explicit health care policy choice. Hospitals obviously have an ethical obligation to provide appropriate care for those who seek it at their facilities. The greatest burden of care for the uninsured in Connecticut falls to larger hospitals in urban areas, with concentrations of people who, generally speaking, have lower per-capita incomes and significantly greater health status problems. I would emphasize, at this point, that the institutions in the Connecticut Health System are not-for-profit organizations that, as public trusts, provide care irrespective of the patient's ability to pay. Thus, once patients arrive at our emergency room or at our clinics, they have access to the full array of services provided by our institution.

At the same time, in fulfilling this obligation, we put our viability at risk. The fact is that providers who serve a proportionately large population of state and Federally-insured patients and uninsured patients, because of geographic location or limited geographic reach of clinical services, face a threatened future. Partly as a result of this situation in our own City, Mt. Sinai Hospital's status, as an independent, financially viable institution, has been altered.

In conclusion, I would point out that the way that the issue of the uninsured is resolved has far reaching implications for access to care for these people, the future financial health and viability of organizations that seek to address their needs, and the costs of care for government and industry. We therefore support a collaborative effort, involving government, business, insurers, and health care providers, that explicitly addresses the ethical, quality of care, and economic issues related to the provision of care for the uninsured.

Thank you very much for this opportunity to share our experience and views with you.

Chairman STARK. I want to thank all of you. If you will bear with us now, the members would like to question you.

Mr. Donnelly.

We will start with Ms. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Just a couple of quick short questions and then a general question to the panel.

Hartford Hospital turned to self-insurance some years ago. Could you give us some sense of the effect on costs and quality of care that becoming self-insured had?

Mr. MEEHAN. Are you speaking about the malpractice self-insurance program, Nancy?

Mrs. JOHNSON. Yes.

Mr. MEEHAN. Yes. Back in 1980, we set up a program with Aetna that has about 11 years of experience, and it has had a very positive track record.

We recently reorganized it last October, but the essential principles are the same, and the bottom line is the rates that we charge, we are able to charge our physician members and the hospital are about 30 to 40 percent less than what they get on the open market, and the track record in terms of claims and settlements is very favorable as evidenced by our ability to charge less.

So I think that has had a direct impact on lowering the cost in its own way.

Mrs. JOHNSON. Ms. Turner, thank you for your excellent presentation about the community health centers in Connecticut. As a system, I am very impressed with what you do and see you as a promising avenue of solution.

However, I am also concerned with what is happening in the malpractice liability system in regards to health clinics. We spend $50 to $60 million a year on malpractice insurance for community health centers out of a total budget of $550 million. So $50 to $60 million out of $550 million is big money. That money could care for 500,000 more people, and your claims are only 3 to 5 million, and as a system, we pay such big premiums.

In your clinic, what kind of costs do you have for malpractice and do you have any idea of how much costs you have in claims and how many people you could serve, were you able to dedicate that money to people and health care?

Ms. TURNER. Well, first of all, our health center has been very fortunate in that we have had no claims. We unfortunately, though, have to pay the going rate for malpractice insurance.

We have been insured through an agreement with Hartford Hospital, which has helped some to keep those costs down. So historically, our rates have run around $25,000 to $30,000 a year. We could see lots of clients for that money.

As you are aware, the community health center national movement is appealing to Congress to approve community health centers under the Federal tort system, so that we would not be liable for malpractice costs and would in effect pay only if there were claims directly against us.

Mrs. JOHNSON. Thank you, and we will be pursuing that with you.

To the panel in general, you know, one of the really difficult issues in this whole area is whether the Federal Government, the public policymakers, are better able to control costs than the private sector. I would ask, particularly the hospital people, from your experience, have our cost control efforts been more effective than your cost control efforts.

Our cost control efforts have been primarily effected through reimbursement levels. The ultimate example of cost control in the public sector is Medicaid, where we have controlled costs by simply not paying, but I think that we need to understand more clearly some of the dramatic changes you have made to control costs, particularly in light of your comments and each one of you did mention managed care.

What has been your experience? How do you think that you can control costs and to what degree?

Mr. MEEHAN. Let me start. One, I think where the public sector in my judgment has given us a clear mandate is in the DRG system, that at least gives clinicians and administrators a common ground to focus in on.

So I think that the DRG systems, although one could quibble about the adequacy of the reimbursement and all, I think as a concept, it was a step forward because for the first time, everybody could speak the same language.

From the standpoint, however, of managing costs, in our personal experience, the best experience we have had was we set up an independent practice association HMO called ConnectiCare that has proved to be one of the few but most successful provider-sponsored HMOs that I am aware of and now has over a 100,000 subscribers, and in terms of utilization and in terms of the attitude of the providers vis-a-vis the managed care experts, it is a very—it is a relatively positive and constructive relationship where they are both looking at costs and quality together at the same table rather than as an adversarial relationship which has happened in a number of the other arenas.

Ms. TURNER. I would like to quickly make a comment on that, also. It may not be politically wise for all, but I think it is important to speak for America's uninsured.

Is the Federal Government better able to control costs than the private sector? I would say yes, and I think that has been proven. I think it is proven in that, first of all, we know that prevention is the aspect that is going to control costs, not cure. If you wait until you treat major problems, the costs are far more excessive, and I think because the administrative overhead is a significant aspect and the fact that the Medicaid and the Medicare administrative aspects are about 3 percent in overhead versus private plans that are at 23 percent, I think the fact that these programs have the type of cost controls that they do make them more effective.

Mr. TANNER. I think the greatest concern that we have is that there is no question that demand for health care is virtually insatiable, and unless someone sets limits, and where best to set these limits than at the national level, we will simply run into difficulty time and time again because of the pressures that are on us to expend dollars in health care.

I believe that a combination of national policy coupled with State-operated programs for overseeing the costs are important.

I have finally come to the conclusion that we need some form of regulation, and I think it is best done at the State level to control the number of facilities that are built, the technology that is added, and how in fact dollars will be spent.

If we do not do that, we will continue to have chaos, and we cannot have either on a locale of city or State policies that differ from a national perspective.

Mr. D'ERAMO. One of the examples that managed care has shown us is that incentives have to be present for all of the participants.

I am talking about providers, I am talking about patients, and I am talking about payers. I think therein lies the key in large part to why we have been reasonably effective, and I think we increasingly are growing so with managed care.

However, the problem goes beyond the ability of managed care to deal with it, primarily because the Government has the overwhelming responsibility at this point in time.

Now, what is the problem? Is there a lack of ability on the part of the Government to deal with it? I am not so sure it is a question of ability versus a question of willingness to deal with it and bite the bullet insofar as some of the difficult considerations that have to occur, but I do think that some of those considerations involve such things as consolidation, Medicare and Medicaid in terms of the management of those two programs is a difficult bureaucracy to find your way through. I think that has to be looked at very closely.

I think capitation, if well done, with proper attention to quality and access issues and not just skirting around the issue, might be an applicable forum for a defined Medicaid population, but I do think we have to look at legitimate risk pooling, also, for instance, in this State, on a statewide basis.

Chairman STARK. Dr. Adams.

Dr. ADAMS. I would just offer the comment that the sense of concentration on access for 33 million uninsured people that we are talking about in this Nation and 275,000 in Connecticut does not relate to those kinds of regulations solely.

Everything is not based on dollars. In my testimony, I tried to heighten the awareness of infrastructure development. As long as funding streams from Washington and all of its subsets continue to segregate prevention centers from local health departments and State health departments and other primary care providers, et cetera, the people that we are talking about will never get in to the loop of this system.

In Hartford, we have a program which is called the Hartford Action Plan on Infant Health, which addresses a lot of the morbidity and mortality related to low birth weight. The Honorable Barbara Kennelly serves on that particular effort, which is impactful.

We need to develop community-based primary care networks to get at the people we are talking about. Not that it is foreign to the system that the other testifiers have commented on related to regulation.

I question whether institutions can self-regulate themselves into the kinds of controls that you are talking about, Representative Johnson.

Chairman STARK. Thank you, and at this point, I would recognize the Honorable Barbara B. Kennelly.

Mrs. KENNELLY. Each one of us has constituencies writing us, calling us, coming to see us in our office, and they all seem to have an idea that there can be a health care system where everybody would get a card and then they will be able to have that health care when they need it.

We are wrestling with a number of questions, who is covered, is it a comprehensive plan, is it a catastrophic plan. We asked you here because you are right on the front lines, you are the providers.

If you could ask us just by starting to do one thing as quickly as possible, could I ask you what that one thing would be? Before we begin to completely take apart the system we have now because you have to remember, whereas 37 million people do not have access, we have hundreds of thousands that do?

[Pause.]

Chairman STARK. Oh, come on. She is tough, I want to tell you. Somebody better have an answer for her.

Ms. TURNER. I hope it is comforting to see that we do not have the answer, either. I would have to say if there is one thing, that that one thing be an emphasis on basically a modified universal plan, the card-type of plan, that focuses purely on the uninsured, and that the funding for this be, and I am obviously biased on the community health center model, but part of that reason is that we are not-for-profit and we do in fact turn many dollars back into uninsured health care, so that anyone who presents at our doors is in fact seen.

So that if we develop a model, realizing that it is going to affect entitlement programs some, but if you amortize the costs of new start-ups for community health centers over time, they will pay for themselves purely in cost savings from improperly utilized existing systems.

Mr. MEEHAN. The first word that came to my mind when you asked is the word expectations, and that may be the hardest thing to deal with, but it is my initial reaction.

That is, all of us who are at the table, the patient, the payer, the employer, the provider, public policymakers, have to somehow get expectations that are reasonable, and we have to be willing to compromise.

My experience is that when people sit at a table, they have one set of expectations, but when they need care, they have another set of expectations, and, so, I think what we all need to do is look very hard at our own selves and what we are able to do and set reasonable expectations and make priorities after that.

I think if public policymakers could, for example, really hammer home that the national priority is going to be on primary preventive health care and then everything goes from that, that would send all of us a major signal that would affect our decisionmaking.

Mr. TANNER. We recently had a patient discharged from the intensive care unit of our hospital, whose bill over the little over a

year they were in the hospital came to slightly over half a million dollars because they spent their entire time in the intensive care unit.

One really wonders what one could have done in our community with that half million dollars. So I think that if I was to start with a very pragmatic program, while you are working on the larger issues, one of the first things I would do would be to attempt to involve the patients.

When they sign up for the insurance programs, no matter what they are now, have them work toward developing a plan should a catastrophic event occur. If you were to take the dollars that we spent during, they call it, their last period or their last admission and redistribute that, we could do so much more for our population as a whole.

Yet, the individual patient must be an informed patient and they must make those decisions before the emergency occurs.

Mr. D'ERAMO. I think you raise a question that has a lot of imponderable dimension to it. I think clearly what we are facing is an era of choices, and it is difficult to know where to start, but I would suggest this, Congresswoman Kennelly. The current situation is aggravated further insofar as there are continued across-the-board cuts to current entitlement programs. I am talking about Medicare and Medicaid. These need to be addressed before we try to fix the system.

The other thing I would suggest is that we focus on outcomes more. I think we are seeing that locally, and the points made across this table about primary care and prevention are real. They can work, but we have not been empowered to really bring to bear the resources we ought to on these areas, and I think that is an area to be considered for the future.

Dr. ADAMS. Very briefly, Representative Kennelly, I would say that you need to wrestle with and fight your way through the morass that prevents a policy which assures universal access, building on the existing strengths in our system, and not calling it a nonsystem.

Mrs. KENNELLY. So Fred, am I to assume by that answer that you mean you take the pieces of the system we have now that are working and build on those and get rid of the ones that are not working and not try to come in with an entirely new system? Is that what you are saying?

Dr. ADAMS. Right now, we have no signal in this Nation for a policy related to the discussion that we are involved in now. Therefore, the Center for Disease Control sets up mechanisms for prevention centers throughout the Nation, absent Connecticut because we did not get an application in, but it does not tie the other primary care networks together because there is no policy that they can be guided by.

So if we are to get to the people that we are talking about through the infrastructure, someone has to send the signal, and it has got to come from Washington.

Mrs. KENNELLY. Thank you, Doctor.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman, and thank you all for your most enlightening testimony.

In response to Mrs. Kennelly's question, you all almost unanimously stated the importance of primary care, diagnostic preventive care.

When we are talking about the uninsured, and when you talk about the uninsured, you are really talking about either the underemployed, the unemployed, the people—the most dispossessed people in our society, the long-term uninsured, how do you get good primary care or diagnostic care when you have a situation where it seems from your testimony, Mr. Tanner, that you have physicians that will not see these folks because of what, the reimbursement? Because of the lack of speed in paying the bill?

What percentage of the physicians, doctor, in Connecticut refuse to take Medicaid patients? Do you have those statistics?

Dr. ADAMS. I do not have those statistics on that at all.

Mr. DONNELLY. You do not keep statistics on that?

Dr. ADAMS. I have a feeling about it. No, not at the Department of Health Services, we would not have anything on that.

Mr. DONNELLY. Give me your feeling about it.

Dr. ADAMS. I would have a feeling from my own professional experience as a dental clinician and public health person that a staggering percentage, over 50 percent, would have unwritten policies and methods of avoidance of those people who do not have a third party insurance or identify themselves as title 18 or 19 people.

So there may be some more specific information about that from my colleagues, but a very high percentage.

Mr. DONNELLY. I would like to ask your colleagues if they would just respond.

Mr. D'ERAMO. In my remarks, Representative Donnelly, I indicated that the patients are utilizing the institutional clinics, et cetera, in place of a family physician. Part of the irony that——

Mr. DONNELLY. Which is the most expensive point of service.

Mr. D'ERAMO. Yes.

Mr. DONNELLY. Because when they come to your emergency room, it is very labor intensive, high technology intensive, where if they had a primary care physician, the problem might have been dealt with in a much cheaper way much more quickly.

Mr. D'ERAMO. Assumedly, part of that condition evolves from the fact that they do not have access to primary care physicians. The other part could be voluntary, but the irony is that the reimbursement even at the clinic level, and this is where the system really breaks down and people are denied access and the problem goes round and round, is terribly inadequate.

So the clinic is compensated less in fact than the compensation for a normal doctor's visit for the same patient entering the system.

Mr. TANNER. It is a combination of underpayment and bureaucratic morass.

We have something called the UB-82.

Mr. DONNELLY. You mentioned in your statement, Mr. Tanner, that poor people end up in your institution because they do not have insurance or primary care physicians will not serve them.

Mr. TANNER. That is correct, and we see that ever increasing, but when a doctor has to complete a document to bill an agency and the background material that explains the physician's office

practice, how to fill out the billing document, is over 200 pages long, it really becomes a nightmare.

So I think the underreimbursement gives a good excuse not to go through the bureaucratic end of the bargain.

Ms. TURNER. Thank you.

There was a 1980 survey in Hartford by the Health Systems Agency that shows that less than 35 percent of primary care providers regularly accepted Medicaid clients. Examples of this are at our health center. We serve South Hartford, we have zero physicians who will accept ophthamology referrals in the area. For medicine specialists, we refer to Hartford Hospital because most specialists are not accepting uninsured low-income individuals, and for Medicare-Medicaid, as Dr. Adams referred to, many of them will tell you on the telephone, yes, we do accept, but they may have an internal restriction for three clients per year and these types of things, so that they get around the obvious admission that they do not accept them.

Mr. DONNELLY. Just one quick followup.

Where do you get your physicians? Is it mostly young physicians paying back college loans at the National Health Service program?

Ms. TURNER. Well, because of the effects of the Reaganomics on National Health Service Corps physicians, we have zero National Health Service Corps physicians at this time. I wish we did have them.

We have an internist, a vacancy for an internist at our facility right now that we are trying to recruit for. It is very difficult for us to get physicians because we do not pay the salaries that many of the hospitals and other providers pay, so that we are very happy about the reinstitution of the National Health Service Corps and hope that will help us in the future.

But we advertise in newspapers, journals, the schools, and things of that nature.

Mr. MEEHAN. Two quick comments. One, it is hard for the private sector to recruit primary care people, internists, obstetricians, pediatricians, just because the system just does not encourage it, and you know that as well as I do.

Second, in a comment that is meant to be constructive, I think it would be good to get direct feedback from the practicing physicians, not the AMA people or the Hartford County Medical Association people, with all due respect, but the person who is managing an office because they really are overwhelmed with some of the things that Alfreda mentioned, and their offices still are busy but they have higher overhead with more staff needed just to do all the paper work, and my worry is that we, in the future, still be able to recruit the best and the brightest to go into the health care professions, including——

Mr. DONNELLY. Well, the reason I asked the question is because we do not have physicians testifying this morning, or at least representatives of their association.

It is important that you people that run the institutions and the State programs give us the perspective of what you think the problem is with physicians not seeing uninsured lower income folks, and then we will give them an opportunity some time later on to give their side of the story.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

I hope I can be heard through my cold. I need some primary care.

This is such a complicated question, Mr. Chairman and colleagues, that I think there is a tendency when you grab at one place, it explodes someplace else. It is always difficult to see what it all means, and there is a lot of verbiage, a lot of concepts, et cetera.

So let me tell you about a couple of situations I learned of while in Michigan visiting an unemployment compensation line. I want to compare what you have been saying and what is going on in my State with these numbers or concepts in terms of real people. OK.

One was a woman in her fifties. She worked in the retail industry in Michigan. There is obviously a contract of some type there. There is a minimum number of weeks and hours one has to work to qualify for health insurance. It was something like 16 weeks, 40 hours per week. She works 15 weeks, 40 hours, and then her employer works her the 16th week 39 hours, and then the 17th week goes back to 40 hours. So she never works 16 consecutive weeks. She never has any health insurance.

Now, I would like to know what you are doing here that relates to this person.

The second was a couple. He is a tool and die maker, very skilled apparently. Because of the state of the tool and die industry in Michigan, which appears not much different than in other States, this man has not been able to obtain jobs directly with employers these last years. Instead, these companies hire through an employment agency, an employment service. That employment service does not pay health insurance, though the company that they hire into does. Obviously, the company is trying to avoid the cost of health insurance and is using the employment agency hiring people.

This gentleman's wife works in an industry where there is no insurance. He works in an industry where there is but he is not covered because of his arrangement, and this has been going on for 10 years.

Now, if you would, give me from your perspective the answer to this. What do you tell those people here in Connecticut, and what do you think I should tell them?

Dr. ADAMS. Well, I think we should tell them the truth, that we have got big problems.

Mr. LEVIN. They know that.

Dr. ADAMS. It is a very human problem, and that is what creates—that is why the legislature created the New Pathway that we are pursuing in Connecticut.

So I can give you Connecticut's response to the very case study reports that you are citing because we heard them from all over the State when we had our series of public forums.

So in Connecticut, we have got several priorities, and this is not verbiage, this is real. Improve Medicaid, develop affordable insurance policies for small businesses, affordable——

Mr. LEVIN. Let me just break in just quickly.

Neither would be eligible for Medicaid. That would not help them.

Dr. ADAMS. All right. And develop special public/private cooperative approaches for our highest priority population, pregnant women and children, and we are working to develop an approach for this population not eligible for Medicaid which would be—which would accommodate what you are talking about but not able to afford private insurance.

This will build on an existing insurance structure but will include considerable State subsidy. The question mark. We do not yet know how this will work in detail, but the Connecticut Health Care Access Commission with the assistance of the Department of Health Service is working very hard on this problem right now.

The latter part would be a sliding scale actuarially possible insurance-related policy that would help those two studies that—case studies that you surfaced.

Mr. LEVIN. Under the Connecticut system as it now exists with these two people, actually three, would they be assured coverage?

Dr. ADAMS. Not unless they would qualify for Medicaid. They are the working poor. They are part of those thousands of people we are talking about.

Mr. LEVIN. Do you want to comment on that?

Mr. TANNER. I think the first example would be a little more difficult to—I am not saying it could not occur, but it would be more difficult to see in our State. The State labor department, I think, does a fine job of looking at what we call living with the intent of the law, and we have had instances where the person, you know, works as you say, the 40 hours *x* number of weeks, and 1 week before, they are dropped, and then are brought back up. This is reported to the State labor department. They investigate it and find that the employer in fact has violated the intent of the law.

Mr. LEVIN. The intent—what law?

Mr. TANNER. Well, we have, for instance—I am sorry. When I say the law, it is usually the policy of the employer; that is, you have to work so many hours and so many weeks. So the labor department will come in and direct that employer to in fact provide coverage for the individual.

Mr. LEVIN. I do not want to practice law, though I am a lawyer. But I think it would be difficult to show a violation of the contract under those circumstances.

Mr. TANNER. Well, we——

Mr. LEVIN. I raise this and we need to go on, but I just want to throw out the challenge here, because I am not sure what the answer is. I think all of us have to step up to the question if we do not cover this kind of instance, is it an adequate response?

Maybe, Mr. Chairman, there is not time for the rest of the panel to respond, but it worried me as I talked to them because as a public official, I had no answer.

Ms. TURNER. First of all, I think in your first scenario, it should be unlawful even if it is not a law in the State, and I feel that an employee who had worked as you described should be eligible at the end of that period for a prorated percentage, if not full percentage, of health insurance coverage.

Your second scenario regarding the couple and the situation, if they hired this gentleman through an employment agency and considering they already have high overhead costs, I feel it should—there should be a mandatory small percentage of contribution that the employment agency should have to pay toward health insurance.

Mr. LEVIN. It does not exist, though, under present Connecticut law. So it is possible that these two instances would have the same result in Connecticut as they do today in Michigan, and I do not mean that critically as much as I think we need to ask ourselves where we are going.

All right. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

I wonder if the four panelists who represent either the health center or the hospitals could cite what the percentage of your charity care is as it relates to your billings for each of your institutions.

Mr. MEEHAN. I had mentioned our bad debts in 1990 were $16 million on gross revenues of about $300 million plus. It is about 4.2 percent of gross.

Mr. DONNELLY. Would the gentleman yield?

I do not think the gentleman is asking bad debt. He is asking charity care.

Mr. MEEHAN. Yes, charity care.

Mr. DONNELLY. Not bad debt and not people that do not pay their bills. Many of us on the committee do not look on that as charity care. That is people that stiff the institution. This is charity care.

Mr. COYNE. Unreimbursed care.

Mr. MEEHAN. OK. It probably is over $20 million in total.

Mr. COYNE. Total?

Mr. MEEHAN. Yes. We are close to $14 million. On billings of about $230 million.

Mr. COYNE. Total on——

Mr. TANNER. We are close to $5 million on about $110 million worth of billings.

Ms. TURNER. Basically, on both of the community health centers, it is running about 10 percent of total budget. That being at our center, which is smaller, about a $100,000 a year; at the other center, about $312,000.

Mr. COYNE. The reason I asked the question, would any of the panelists be in favor of folding unreimbursed care into the disproportionate share formula, and if so how would this benefit your institution?

Mr. D'ERAMO. It depends on what you mean. Currently, there is a calculation for disproportionate share that takes that into account the level of that.

Chairman STARK. Excuse me. We, for posterity, are taking this all down, and our court reporter is in the back of the room, and if we do not use the mike, your words of wisdom are not going to go back with us.

So I would thank you very much if you could do that.

Mr. D'ERAMO. Currently, there is a formula to calculate disproportionate share. I do not think there is much question that there are holes in that formula. The current formula does not allow institutions that are bearing an increasing level of "charity care" because of the people falling through the cracks in terms of underinsurance and unreimbursed care.

Mr. COYNE. So you would maybe look with some positive position on that?

Mr. D'ERAMO. Yes.

Mr. TANNER. I believe that if this was done at the Federal level, it would in fact help.

In Connecticut, because we are a rate-regulated State, one of the few in the country, our undercompensation is recognized by the rate-setting authority and they build that into your rate for the following year. The difficulty is that if you have a disproportionate share of free care and undercompensated care, although you are given rate relief, you then suddenly become noncompetitive because your rates become so high that the private employer then puts in disincentives to his employees to use your facility.

So that if this could be leveled at the national level, it would really help.

Mr. COYNE. Thank you very much.

Chairman STARK. Thank you.

I have just a couple of observations and a question or two for the panel. I heard a question about whether they thought that the Federal Government is doing a good job of controlling costs, and it is important that I state here in Connecticut that I know we are. We are cutting severily the hospital costs, but that is my fault.

Barbara and Nancy fight me all the time. They want to cut costs in California, and I cut costs in Connecticut. They are your heroes, and in spite of everything I try to do, it is these two ladies who save the hospital industry in Connecticut from my cost cutting, and I take full responsibility in Connecticut. [Applause.]

But they have got to say that in California.

Now, Dr. Adams, in reading through someone's testimony coming out on the plane, I saw a figure somewhere of $2,699 for the average cost per capita in Connecticut for health care in 1990.

Is that a ball park number that you are aware of?

Dr. ADAMS. I am not aware of that specific figure, but that would be a ball park figure.

Chairman STARK. OK.

Second, a political question since I believe you hold a political office. I am looking at the Connecticut health care plan, but at the same time I am reading about your new Governor's attempt to raise taxes and the budget problems that Connecticut has. Is it reasonable to expect, and I ask this without knowing the answer, that Connecticut is going to want to spend the money or have the money to pick up their share of this increased Medicaid benefit?

Is the Medicaid expansion within the realm of possibility or are we just talking about a plan here that is going to leave out the lower-income population in Connecticut because of the State's own budget problems, not because of an unwillingness of your politicians to want to do the right thing. But without the money, will

they be able to raise the Medicaid benefits as a practical matter to cover the poor population as this plan envisions?

Dr. ADAMS. I think that is a fair question. I know very little about politics; therefore, I will be the former commissioner of the State come March 1. So that should substantiate that.

You hit the heart of the matter. It is going to be costly. It is going to run into the multiples of millions. It is going to be competitive with other priorities, not only in the near term but in the long term. I cannot speak for the new administration and what their priorities are going to be. However, the standard bearer has talked about children as a priority. Children is common threaded through my remarks.

So I think it is, to answer your question, it is going to be a phased step toward the end. It is not going to be one fell swoop and we will implement the whole thing tomorrow. But I do not think it will go away. I think the Connecticut Health Care Access Commission, and you will hear much more testimony from them, is so diverse and representative of the will of this State that politically it will not go away.

Chairman STARK. An aside. Do you think that any member of the Connecticut Health Care Commission was uninsured?

Dr. ADAMS. No, not at all.

Chairman STARK. We have not had any in our commissions either, but it is always an interesting question. I was on the Pepper Commission, and I have seen—and there has never been an uninsured person on the commissions.

So I always feel that we do not quite understand the urgency that the people without insurance feel.

Do you think if insurance becomes available at a reasonable cost, whatever reasonable cost, a couple of thousands—let us say $2,500 a year, that the service workers and the fast-food workers and the construction workers who may work part-time are going to have this insurance available to them from their place of employment? What does your gut tell you?

Do you think you are going to get all of the people who are now uninsured covered?

Dr. ADAMS. No, I do not; but I think it will be a step in the right direction and over time certainly will be able to attract the critical mass.

Chairman STARK. I guess my prejudice is coming forth. I believe that we have to leave behind this vestige of employment-based insurance for those who do not fit the traditional employment mold of working 40 hours a week, 50 weeks a year.

We are dealing with people who are on the marginal end of the job market, and I do not personally see any way that we can do anything but allow everyone coverage. No ands, ifs, or buts. Now, we may not be able to give everybody as many benefits as we want to begin with, but let us put everybody in the box and not worry about who pays for the kids.

If we have an employer-based system, what do you do when you have two working parents? Does one employer pay for the kids or does the other? Why? I mean there are a whole lot of potential problems—but those are my prejudices, and it would not be fair to the other witnesses if I did not say that.

Dr. ADAMS. I would just say, however, that I would not bet everything on a national health insurance. A national health policy is distinctly different and everything is not predicated on dollars for access.

Chairman STARK. There is no question about that. I am just suggesting that at this point in the decisionmaking, it seems to me that you have got to go one way or the other. You either have to take what we call the social model of access, which basically says we are going to cover every resident of Connecticut, or you say coverage has to come through the employer. If you do that, then you have to do a whole lot of twisting and fudging and fishing to put square pegs in round holes if they do not quite fit the employment pattern.

And without any prejudice to whether that is a State law or a Federal law, I am just saying that it has always troubled me to keep hanging on to this employment-based model when it is the erratic nature of the employment which often causes the problem.

I wanted to ask Dr. D'Eramo two questions. The cost-shifting thing is something that you bring up in your testimony, and you list six areas.

Mr. D'ERAMO. Yes, yes, that is correct.

Chairman STARK. I am going to make a statement, and I wonder if you would agree with this. It really does not make any difference if you allow people to bargain, if CIGNA comes to your hospital and says I have got 10,000 people and I want you to cut your daily rate, you do not have much choice. So you then have to raise the rate on somebody else, do you not?

I mean does it make any difference if Medicare cuts your payment or Medicaid? As long as anybody is pushing on you for a lower price, you have got to adjust over here and unless there is a fixed rate that you cannot deviate from either by law or because you control the market, it does not make much difference who is cost shifting, or does it?

I mean do you care who is bargaining the toughest?

Mr. D'ERAMO. Yes, unfortunately, on two scores, because I have friends in this audience and we are in a deregulated State.

We do have that delimiting factor that we have to work within. So there is a——

Chairman STARK. You are prevented from cost shifting?

Mr. D'ERAMO. To a certain extent.

Chairman STARK. What a wonderful State.

And I also wanted to ask, because I am faced by your trade association each year with this threat of the sword of Damocles of hospitals closing, and you represent a hospital that is closed, but it is still open, is it not? Was that closing the end of the world or are mergers sometimes closures which can be a blessing in disguise if two groups get together and find a way to work out their problems?

Mr. D'ERAMO. Well, it has not closed, but it was on the precipice of perhaps having to face closure and still is, but we are slowly ameliorating some of those problems. It is a painful situation, and the prognosis for the future is still one where a cloud is hanging over us because we are a disproportionate-share institution with large concentrations of Medicare-Medicaid and underinsured. So,

the continued discounting on governmental reimbursement does not help that situation very much.

Chairman STARK. I am going to ask you the question and ask the other two hospital administrators to see what they say.

If you received the Medicare rate for every patient who walked through your door, could you survive?

Mr. D'ERAMO. No.

Chairman STARK. No.

Mr. D'ERAMO. No.

Chairman STARK. You need higher than Medicare. You would have no more uncompensated care, now, think about that. No uncompensated care, no charity. If you got the DRG rates for every patient who came through the door, could you make it?

Mr. D'ERAMO. I have not calculated it quite that way.

Chairman STARK. Oh, I would include Medicaid. And remember that there are those who say that if you have a single payer you would lose about one employee per bed just in bookkeeping.

Could you make it——

Mr. D'ERAMO. The answer is——

Chairman STARK [continuing]. With that——

Mr. D'ERAMO [continuing]. No. I would be surprised if we could.

Chairman STARK. You do not think—Mr.——

Mr. D'ERAMO. I have never calculated that.

Chairman STARK. Would you? Really, I would love to know some time just to see where we might be if you had no uncompensated care, no bad debts and some savings obviously for a single payer.

Mr. Tanner, Where would you come out on that?

Mr. TANNER. I think it is, as with both John and Dave, it is an issue. It has to be calculated. However, I think that it would be important in developing this Medicare rate to recognize the differences in geography, teaching versus nonteaching, urban versus not.

Chairman STARK. Well, we already do. We may not do it adequately or equitably, but I mean we make some differences for teaching and for disproportionate share. If you got in your hospital your current Medicare rate, whatever it is, whether your disproportionate share or where you are, for every admission, could you exist?

Mr. TANNER. I think it would be awfully close.

Chairman STARK. I just ask that question for my own edification, and I—because it is an issue that is important.

I wanted also, Mr. D'Eramo, to mention the Canadian issue, which you mention in your testimony. I hope you agree with me that while the length of the lines in Canada are greatly overrated largely by the physicians in this country who do not like the system, that whatever rationing goes on in Canada is done clinically, whereas the rationing in our country is decided by poverty level, not by what the doctor thinks. That is the case at least in my district in Oakland, Calif., where we have equally long lines.

Would that be a fair comparison?

Mr. D'ERAMO. Well, I am not sure the clinician is the instrument or the actual cause of the rationing. I mean as I understand the Canadian system, they get a certain amount of resources each year, and there are certain coverages that pertain.

So——

Chairman STARK. Well, the hospitals do.

Mr. D'ERAMO. The hospitals.

Chairman STARK. The hospitals are on an annual budget.

Mr. D'ERAMO. Correct.

Chairman STARK. But the doctors' incomes depend on how much they work. The fee is set, but there is no cap. But—OK. I wanted to tell Ms. Turner that it was this committee with the help of Congresswoman Johnson that eliminated the lower of cost recharges for what little Medicare pays to your community health centers. As in your district, community health centers are a tremendously important way to provide health care services in my own district. I know in the rest of our districts, we wish we could find ways to help these centers, too.

We are accused often by the senior citizens of using Medicare to subsidize other types of insurance or other types of health care, and your community center is one of them. I wish we could do more because—

Ms. TURNER. I just thank you for survival.

Chairman STARK. Of course, we politicians thank our constituents for that every couple of years. I just wanted to mention that.

Thank you very much. We have another panel to come before us.

If any of you would like to comment later, just drop us a note on that issue of where the Medicare payment level would come. It is one that is of real interest to us, and I appreciate your taking the time to be with us this morning.

Our next panel—well, thank you all. [Applause.]

You might all like to stretch for a second while we call these next witnesses up, and as you stretch, I am sure some of the people who have been standing are going to steal your seats.

We will be hearing from Mr. Craig Leroy, the president of the Insurance Association of Connecticut. We will be hearing from Mr. Harry Torello, president and chief operating officer of the Blue Cross/Blue Shield of Connecticut. We will be hearing from Mr. Charles Paydos, the executive vice president of Phoenix Mutual Life Insurance Co., accompanied by Joan Herman, who is the senior vice president; and from Mr. G. Robert O'Brien, the president of the Employee Benefits Division of the CIGNA Corp.

[Pause.]

Chairman STARK. If I could ask our guests to move about with some quieter conversation. We have a distinguished panel, and we would like to move along. It is the intention of the Chair for those of you who wonder or want to plan ahead to work right on through lunch, and, so, we will be continuing. If I could ask the audience to just hold down the conversation for a moment or two, I would like to call Mr. Craig Leroy, who is the president of the Insurance Association of Connecticut. I am sure that you would all like to hear his comments. He is the man who is going to bring you the new insurance program that the State of Connecticut is about to bring in, and if you do not listen very closely, you are not going to know a lot about it.

Thank you very much.

Mr. Leroy, would you like to proceed in whatever manner you are comfortable?

**STATEMENT OF H. CRAIG LEROY, PRESIDENT, INSURANCE ASSOCIATION OF CONNECTICUT, ACCOMPANIED BY JOHN F. TROY, VICE PRESIDENT, MANAGED CARE AND EMPLOYEE BENEFITS OPERATIONS, THE TRAVELERS CO., AND CHAIRMAN, CONNECTICUT REINSURNACE POOL**

Mr. LEROY. Mr. Chairman, it is a great pleasure to be here today to join you.

I would like to discuss one of the most pressing issues in our country's health care system, the issue of access to health care. This is a nationwide concern as you are aware, and it is a multifaceted problem that affects a diverse population and one that involves not only access to care but cost of care.

Here in Connecticut, we have paid attention to the concerns. We have adopted a public-private partnership aimed at increasing the number of individuals in the State with health coverage.

My focus today will be on the significant steps we have taken here. We believe that the Connecticut reforms can serve as a model for other States.

In 1989, Connecticut created a Blue Ribbon Commission to develop a plan to expand access to health care. The commission faced a very serious problem. Over 270,000 people, 10 percent of our population, were uninsured. Two-thirds of the uncovered adults were employed; two-thirds of those were employed in small businesses, those with fewer than 25 employees.

The commission was a diverse group, representing both large and small businesses and a multitude of providers as well as interest groups. The debate was lively, to say the least. They debated, for example, employer mandates, requiring the employer to provide insurance for employees, but abandoned it as too onerous, especially for small business.

They considered a universal unitary approach along the lines of a Canadian system, but rejected it because the State could not afford it. The residents of the State, like people nationwide, were not inviting legislatures to impose substantial new taxes on them. There was also concern that the system might adversely impact the high quality of care we enjoy here in the State of Connecticut.

They adopted instead a proposal originally made by the insurance industry which quickly gained widespread support and was designed to make our system work better. Throughout the process that led the commission's acceptance of this approach, we in the industry were motivated by our belief that we could make the system work better for health care consumers, and by the conviction that we had an obligation to do so.

The plan originally put forward by the industry quickly became the focus of debate in the Blue Ribbon Commission, and after some modifications was adopted unanimously. It moved through five legislative committees and adopted by both houses of our State legislature. I think it is worth noting that of over 300 votes cast, there were only 10 "Nos" during the entire process.

The act, which generated overwhelming support, reflects the diversity of Connecticut's uninsured population by setting forth a multiple set of solutions. At its heart is the concept of a public-private partnership.

Under the plan, State government takes responsibility for increasing access to health care for the poor and near poor. The act authorizes several approaches to this, much of which has been discussed already by Dr. Adams.

In turn, the private sector undertook to make the private health insurance market work better by making health insurance more available and more affordable to small employers who experience unique problems because of high medical insurance claims. As an industry, we have accepted significantly tougher regulation.

First, Connecticut created new, more affordable health insurance policies for small businesses that had had no insurance the previous 2 years. The commission identified cost as a primary barrier keeping small businesses from buying health insurance, as have a number of other small business associations. The new blue ribbon policy, as it has become known, was designed to address this issue of affordability. It is a basic policy covering all State mandates.

Health insurance companies, as you know, have in the past offered suggestions to preempt State mandates. However, the commission did not find that acceptable. The commission felt that a more appropriate approach to affordability was to limit reimbursements to a percentage of the Medicare rate. The industry is committed to marketing this product.

Second, Connecticut guaranteed availability of health insurance to all employers of 2 to 25 individuals and undertook other significant reforms of the small group market. Insurers must make small employer health care plans available to all small businesses. There will no longer be employees who are uninsurable, so employers will no longer face a choice between firing these workers or leaving them without coverage.

Further, once an employer is insured, coverage cannot be discontinued for any reason except nonpayment of premium, fraud or misrepresentation. Bad claims experience is not grounds for cancellation, and no matter how bad an individual's medical history may be, no individual may be excluded from the group.

The law also restricts significantly the use of preexisting condition limitations by ensuring that covered employees can change employers without preexisting condition limitations being applied.

It also places limitations on insurers to restrict differences in rates between the best and worst risks. In other words, the law will end the horror stories of three-digit rate increases.

It is worth noting that while rate increases will be limited on the annual and overall basis, the real issue, that is the need to control costs of health care, must still be addressed.

Finally, Connecticut created a safety net in the form of a reinsurance pool to cover high-risk individuals and groups. This reinsurance pool will make it possible to cover groups that were previously not underwritten by spreading the costs associated with these risks across the broadest possible universe. That is the role insurance should play.

It is worth noting that there is no Government money involved in the private sector reforms. I firmly believe Connecticut's experiment with small group reform will justify the confidence of the Blue Ribbon Commission in this approach. The industry spent hun-

dreds, if not thousands, of hours working to implement the reforms.

Comprehensive reform does not come easy. It took much debate and much work to get to where we are. We are happy that the Health Insurance Association of America, which represents the health insurance industry nationwide, has agreed to support similar reforms in other States at a recent board meeting.

Mr. Chairman, that concludes my prepared remarks. I will be pleased to answer any questions you have.

[The statements of Mr. Leroy and the Travelers Insurance Co. follow:]

Statement of

H. Craig Leroy
President, Insurance Association of Connecticut

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Hartford, Connecticut
February 25, 1991

Mr. Chairman, it is a great pleasure to join you here today, to discuss one of the most pressing problems in our country's health care system -- the issue of access to health care. This is a nationwide concern, as you are well aware. It is also a multi-faceted problem, one that affects diverse populations, and one that involves not only access to but the cost of care. As such, the issue cannot be addressed with any one solution. But despite its size and complexity, access to health care is a problem that demands our attention.

Here in Connecticut, we have paid attention. We have adopted a public/private program aimed at increasing the number of individuals in the state with health coverage. My focus today will be on the the significant steps we have taken here, and why we believe that the Connecticut reforms can serve as a model nationwide.

In 1989, Connecticut created a Blue Ribbon Commission to develop a plan to expand access to health care in the state. The Commission faced a serious problem: about 270,000 people -- 10 percent of the non-elderly population -- were uninsured. Two-thirds of uncovered adults were employed, and two-thirds of those were employed in small businesses, those with fewer than 25 employees.

The Commission was a diverse group, representing both large and small businesses, insurers, doctors, hospitals, community health centers, the disabled, consumers, labor unions, state officials, and so on. Their debate on the best way to address issues of access was wide-ranging and lively. No possible approach was off-limits.

They debated, for example, employer mandates -- that is, requiring each employer to provide insurance for employees -- but abandoned it as too onerous, especially for small businesses. They considered a universal unitary approach -- along the lines of the Canadian system -- but rejected it. First, the state could not afford it; the residents of Connecticut, like people nationwide, are not inviting legislators to impose substantial new taxes on them. Second, there was concern that such a system might adversely impact the high-quality health care we enjoy here in Connecticut. They adopted instead a proposal originally made by the insurance industry, which quickly received widespread support and was designed to make our present system work better.

Throughout the process that led to the Commission's acceptance of this approach, we in the industry were motivated by our belief that we could make the system work better for health care consumers -- and by our conviction that we had an obligation to do so.

The plan originally put forward by the industry quickly became the focus of debate in the Blue Ribbon Commission, and after some modifications, was adopted unanimously. The Commission report was then approved by five legislative committees, and adopted by both houses of our state legislature. I think it is worth noting that, of over 300 votes cast on the issue, there were only 10 "noes."

The act, which generated such overwhelming support, reflects the diversity of Connecticut's uninsured population by setting forth multiple solutions. At its heart is the concept of a public/private partnership to increase access to health care, with each sector attacking a different aspect of the problem.

Under the plan, the state government takes responsibility for increasing access to health care for the poor and near-poor. The act authorizes several approaches to this: providing for expanded access to Medicaid for pregnant women, low-income children, and the disabled, for example, and offering direct grants to health care providers who serve the uninsured poor.

In turn, the private sector undertook to make the private health insurance market work better, by making health insurance more available and more affordable for small employers, who experience unique problems due to high medical insurance claims. As an industry, we have accepted significantly tougher regulation.

First, Connecticut created a new, more affordable health insurance policy for small businesses that had had no insurance for the previous two years. The Blue Ribbon Commission identified cost as the primary barrier keeping small businesses from buying health insurance, as had a number of small business associations. The new "Blue Ribbon Policy" was specifically designed to address this issue of affordability. It is a basic policy covering all state mandates. All health insurance companies will offer it, and, as I said, any small business that has not had health insurance for the past two years can buy it. The industry wanted to make this product available by reducing mandated coverages, an approach which it still finds desirable. The Commission, however, felt that a more appropriate approach to affordability was to limit reimbursements to a percentage of the Medicare rate. The industry is committed to marketing this product.

Second, Connecticut guaranteed availability of health insurance to all employer of 2 to 25 individuals, and undertook other significant reforms of the small group market. Insurers must make small employer health care plans available to all small businesses. There will no longer be employees who are uninsurable, so employers will no longer face a choice between firing those workers or leaving them without coverage. Further, once an employer is insured, coverage cannot be discontinued for any reason except non-payment of premium, fraud, or misrepresentation. Bad claims experience is not grounds for cancellation, and, no matter how bad an individual's medical history may be, no individual may be excluded from the group.

The law also significantly restricts the use of pre-existing condition limitations by ensuring that covered employees can change employers, without pre-existing condition limitations being applied.

SB 342 also places rate limitations on insurers, to restrict differences in rates between the best and worst risks. In other words, this law will end the horror stories of three digit rate increases. It is worth noting however, that while rate increases will be limited on an annual and overall basis, the real issue -- that is, the need to control the cost of health care -- must still be addressed. The rising price of health insurance premiums are only a reflection of the rising costs of medical care. The industry is working hard in the area of managed care to attempt to restrain these costs.

Finally, Connecticut created a safety net, in the form of a reinsurance pool to cover high risk individuals and groups. This reinsurance pool makes it possible to cover groups that were previously not underwritten by spreading the costs associated with these risks across the broadest possible universe. That's the role insurance should play.

The insurer will pay a reinsurance premium for any risks it decides to cede to the pool. Depending on the circumstances, employers will pay some or all of that premium. Individuals covered by reinsurance would be handled just like other covered employees. Their claims would be paid by the insurer, which would then be reimbursed by the pool. If the pool's claims exceed the premiums received -- which, incidentally, we fully expect -- insurers will be assessed to cover losses. The industry is carefully monitoring the level of losses to avoid an overly negative impact on all medical insurance premiums.

It is worth noting that there is no government money involved. The pool is a purely private undertaking, in keeping with the spirit of the small group reforms overall. The intention of the Blue Ribbon Commission, after all, was not to scrap the private health insurance system -- but to make that system work better.

I firmly believe that the Connecticut experiment with small group reform will fully justify the confidence of the Blue Ribbon Commission in this approach. Small employers will find health insurance more available and more affordable. Employees will enjoy the benefits of guaranteed coverage within a group and limits on pre-existing condition limitations. And the reinsurance pool will guarantee that small groups have continuing access to the market.

The insurance industry in Connecticut has spent hundreds, if not thousands, of hours working to implement the reforms. We have met every deadline imposed by the legislation, and anticipate no problems in meeting future timing requirements. As a member of the Health Care Access Commission, created by SB 342, I am working closely with that group, both to look at the implementation of the law and to examine new issues and new approaches. All parties, including Blue Cross/Blue Shield and out-of-state companies, are cooperating to ensure the success of this effort.

This comprehensive reform does not come easy. Even within the industry, there was substantial debate and dialogue. But by studying, learning, and working together, very disparate elements -- consumers, health care providers, labor unions, insurance companies, and so on -- of society were able to reach common ground. The process undertaken in Connecticut, and the solutions reached as a result, are, I believe, a model for other states.

Some IAC members are among the largest small group insurance writers in the United States. As leaders in the effort to reform health coverage for small employers, we in the Connecticut insurance industry are very pleased that the Health Insurance Association of America, which represents the health insurance industry nationwide, agreed to support similar reforms at its recent Board meeting. We and the rest of the industry are now pursuing adoption of such reforms in a number of states across the country.

Mr. Chairman, that concludes my prepared statement. I will be pleased to answer any questions you may have.

**Statement of The Travelers Insurance Company**

The Travelers was represented at the Subcommittee's February 25, 1991 hearing in Hartford by Craig Leroy, President of our domestic trade association, the Insurance Association of Connecticut (IAC). Mr. Leroy outlined the efforts of the IAC to bring about meaningful reform in the small group health insurance market in Connecticut, which resulted in the successful passage of Public Act 90-134, concerning access to health care in Connecticut. The law enacts the reform proposal developed by the IAC and makes Connecticut the first state to enact effective, comprehensive reform in the small group market.

The Travelers is one of the largest writers of health insurance for small businesses (2 to 50 employees) in the country. In 1990, we had over $1.1 billion in premium in this market, which makes us either first or second in premium for commercial carriers. We cover over 51,000 small employers and over 730,000 lives in this small group market. As part of this business we cover 13 state manufacturers associations, providing coverage to their small employer members. Fifty percent of our small group business is in managed care plans, with 2/3 to 3/4 of our new business going into managed indemnity and PPO plans. More comprehensive managed care programs will be offered in this market later this year. We are strongly committed to the small group market and to controlling costs in this market through effective managed care.

As a major player in the small group market, we recognized some time ago that rating and underwriting practices were being driven by competition to a point where coverage was becoming unaffordable or unavailable for too many small employers. Everyone wanted to write the healthy cases but no one wanted to write the high risk cases. Serious reform was necessary.

Travelers has participated in the development of the Health Insurance Association of America (HIAA) access to health care proposal from the beginning. We played a leading role in the development of the IAC proposal. Travelers was one of only two commercial insurers on the Connecticut Blue Ribbon Commission on State Health Insurance, whose recommendations led to the passage of Public Act 90-134. We currently chair the Advisory Committee to the National Association of Insurance Commissioners (NAIC) Health Care Insurance Access Working Group, which is developing model legislation on small group health insurance reform which is very similar to our Connecticut law. Travelers also chairs HIAA's State Access to Health Care Task Force, which is charged with pursuing reform measures in the states.

Once Public Act 90-134 became law in Connecticut, we sent copies to the legislative leadership and insurance commissioners in all fifty states, as well as Congressional leadership on committees with jurisdiction over health insurance. We believe that Public Act 90-134, with its reforms in the small group market can serve as a model for the other states, recognizing that modifications will be necessary in other states. Those reforms will:

1. guarantee coverage for all small employers,
2. guarantee the continuation of such coverage,
3. place restrictions on experience rating,
4. make available reinsurance for high risk cases, and
5. make available low cost coverage.

Public Act 90-134, and similar legislation being proposed by the HIAA and the NAIC, is an incremental step in a much larger process that will be necessary to provide access to health care for all Americans. It builds on the existing mix of public and private sector insurance, which we believe is appropriate. It requires no public funding as to small group insurance reforms. The reinsurance facility created under the law is funded by the insurers in the health insurance market.

Massive public sector control of access to health care is fiscally impossible at either the state or federal level and there is no consensus for such reform. Our goal has been to move quickly to solve those problems that can be solved now, building on the current system as we develop longer term solutions for those currently not covered, hopefully controlling the cost of health care in the process.

The Connecticut Blue Ribbon Commission and the Legislature ultimately decided that it was more important to reach consensus and do something achievable than to continue to engage in the high minded debate that has divided the country on access to health care for over 20 years. That debate will go on, but small employers in Connecticut can now get coverage where it was previously denied and can afford to keep coverage that was previously being priced to drive them out of the market. It is easy to say what our law does not do. What is more important is that we rose above the debate in Connecticut and made the critical first step to full access for all citizens.

Travelers has carried the message of small group reform to many other states, following our mailing of the Connecticut law to all states. We have participated in business and consumer coalitions in a number of states and testified before legislators, regulators and study commissions in approximately 15 states in 1990. As the administrative carrier in Connecticut under the new law, we have offered our assistance to other states considering similar laws. Bills similar to the Connecticut and HIAA bills have been introduced in California, New Jersey and Maine and are being seriously considered in Ohio, Massachusetts, Texas, Minnesota, Mississippi and Vermont. Other states such as Georgia, Florida, Delaware, Colorado and North Carolina are discussing similar approaches. Once the NAIC has completed work on its model small group access reform bill, we expect many other states to quickly consider this approach.

The states continue to be the place for experimentation and action on these access to health care issues and we strongly support this state level activity. The diversity of provider communities in the states, the dramatic differences in treatment of the poor by the states, and the differences in the nature of the Blues plans and HMO's from state to state (with some providing guaranteed issue and others acting like commercial carriers) require modifications in any reform proposal that is best achieved state by state. While this can be a frustrating process, it is necessary if reform programs are to work in the states. No federal solution to the problems in the small group market could properly reflect and accommodate the dramatic differences in the delivery system and the nature of the insurance market among the states. Such a federal solution would only require detailed implementation in each state. It makes more sense to go directly to the states to accomplish the goal of meaningful reform. In addition, the diversity of the uninsured population means that no one solution will fit the needs of all.

Federal legislation to exempt small employers from state benefit mandates would be helpful. We are pursuing similar exemptions in the states. Nine states have passed laws permitting the sale of low cost policies to small employers, without the state mandates. Travelers is actively marketing such low cost plans in Virginia, Kentucky and Illinois and will pursue such programs in other states with similar laws. Federal legislation on benefit mandates would accelerate this process and enable more employers to purchase more affordable coverage.

Tax credits for small employers who purchase health insurance, especially as to the self-employed, would also be helpful in encouraging more employers to buy health insurance.

Most of the new jobs in America will be created by small businesses. Travelers is strongly committed to providing cost effective coverage to this market and to enacting meaningful reform legislation in the states so that coverage can be provided to all small businesses. We urge your committee and the Congress to allow the states to address these problems without unnecessary federal interference.

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Mr. DONNELLY. Thank you, Mr. Leroy.

The next witness is the president and chief operating officer of Blue Cross/Blue Shield of Connecticut, Mr. Harry Torello.

**STATEMENT OF HARRY J. TORELLO, PRESIDENT AND CHIEF OPERATING OFFICER, BLUE CROSS AND BLUE SHIELD OF CONNECTICUT**

Mr. TORELLO. Thank you, Mr. Donnelly.

Members of the committee, I thank you for this opportunity to testify here today.

Blue Cross and Blue Shield of Connecticut covers over 1 million citizens of our State and about 50 percent of the small group market, all with the benefit of managed care programs.

We share your concerns about the problems faced by small employers purchasing health insurance. I am appearing here today to discuss Connecticut's small group market reform legislation, P.A. 90-134, as a potential model for action in other States.

The primary problem small employers face in deciding whether to purchase health insurance coverage is one of cost. The inability of small employers, particularly those with high-risk, high-cost employees, to obtain health insurance coverage is a relatively recent phenomenon. It has risen in response to competitive forces driven largely by efforts to provide lower cost coverage to small employers.

As health care costs escalate, employers began to resist provider and payer efforts to distribute costs among insurer groups through such mechanisms as community rating. These demands led many insurers to select and rate groups based on risk through the use of experience-rated approaches. This shift has brought insurance costs down for many small employers, but it has exacerbated the affordability problem for a growing number of small employers, especially those who remain in community-rated programs.

It became increasingly difficult for carriers to accept all applicants and maintain competitive prices. Many carriers now reject high-risk groups and rely in varying degrees on groups' own experience to set its rates. However, some carriers have maintained their early practices. We generally have not used medical underwriting to deny coverage to high-risk small groups, nor have we ever used the small groups' own experience or health status to establish its rates.

We have continued to community-rate our small groups' products, although we have had to move away from pure community rating because of competitive pressures. We now adjust our community rates for small groups based on a small group's demographic characteristics.

The more aggressive practices of our competitors enable them to skim off our good risk groups, resulting in an adverse selection spiral in our business. Because of our new legislation, we have been forced to adopt medical underwriting in order to assess the risk of small group applicants for the purpose of the private reinsurance mechanism. This represents a significant change in the way we do business.

However, it is a necessary requirement if we are to continue to offer coverage to small groups under the new legislation.

We also will begin adjusting small group rates to reflect the underwriting risk or experience within the limits allowed under the new law.

In evaluating this legislation as a model, it is important to understand what the legislation will and will not do in Connecticut. The carrier reforms and the mandatory reinsurance programs probably will result in increased costs for many small employers for the following reasons:

The rating reforms will require carriers that currently use experience ratings to narrow the range of rates charged to small groups, increasing rates for lower-risk groups.

The guarantee issue requirement and the reinsurance pool will distribute the cost of covering high-risk groups throughout the market and will also result in potentially higher rates for lower-risk groups.

The overhead costs associated with administering this complex new reinsurance program also will increase costs.

We have grave concerns about the requirement to provide that providers be paid 75 percent of Medicare payment rates for products sold to currently uninsured groups. The cost shift resulting from inadequate Medicare and Medicaid payments rates in Connecticut totaled $650 million last year. Our concern is that unless public funding of these entitlement programs is improved, this legislation will exacerbate the affordability problem already faced by small employers currently providing health insurance coverage.

To maintain costs, we support exempting all products sold to small employers from State mandate, which can reduce costs up to 15 percent. This exemption was not included in the legislation.

While we will continue our efforts to make the legislation work as well as possible, I do feel there are better alternatives. I should note that availability of private coverage for small employers has not been a problem in Connecticut.

Because of our practices as well as those of other carriers, coverage generally has been available to small groups. While one goal of the legislation is to move carriers away from risk selection practices, it in fact encourages continued use of medical underwriting. Medical underwriting is needed to identify which small groups to reinsure because all carriers are required to participate in the reinsurance program.

Consequently, the legislation has forced us to adopt the practice of medical underwriting, to identify which groups to reinsure, and to appropriately adjust rates in order to remain competitive.

We believe it is premature to state that this legislation represents the best solution to the problems in the small group market from a national perspective. Some of the design elements included in the Connecticut legislation may be problematic if adopted in other States. Our key design element is whether all carriers should be required to participate in the reinsurance mechanism.

While we do not oppose the mandatory participation here, some Blue Cross and Blue Shield plans and HMOs in other States should/would prefer the voluntary approach. In such States, we believe it would be appropriate to permit these carriers to opt out of

the reinsurance program as long as they accept all small groups for coverage and meet the same rules as other carriers with respect to their rating and renewal practices.

Another key element is the volume of claims covered by the reinsurance mechanism and the assessment mechanism used to finance the program losses.

The assessment structure in the Connecticut legislation relies, first, on the small group market and then on the large group and individual markets. A key concern is the inequity of assessing larger group business while ERISA will protect self-funded groups from helping to finance program losses.

We believe any assessment beyond the small group market would be/should be broad-based.

Another important consideration is how much of the risk is retained by individual carriers versus spread to the rest of the market. This has implications for incentives to manage the cost of high-risk cases and the need for assessments to finance pool losses.

We believe it is critical to assess carriers—to assure carrier accountability in accepting and managing risk and to encourage cost containment.

Finally, the degree of administrative complexity and costs involved in establishing a reinsurance mechanism continues to be of concern. We believe States should have flexibility to adopt less competitive approaches.

We have been working with others to suggest needed improvements to the reinsurance program. Given the untested nature of this program and the need to make significant changes in the original design, we believe it would be inappropriate to review this legislation as a model for other States as a national model.

We believe the untested nature and the complexity of the small group reform proposals as well as the different State environments necessitates State flexibility to experiment with different approaches. We therefore urge you to reject the single solution approach to this complex problem.

Thank you.

[The prepared statement follows:]

STATEMENT OF HARRY J. TORELLO, PRESIDENT AND CHIEF OPERATING OFFICER, BLUE CROSS AND BLUE SHIELD OF CONNECTICUT

Chairman Stark and members of the subcommittee, I appreciate the opportunity to testify before you today. My name is Harry Torello and I am President and Chief Operating Officer for Blue Cross and Blue Shield of Connecticut. Blue Cross and Blue Shield of Connecticut covers over one million citizens of our State and represents approximately 60 percent of the total premiums underwritten in this State. We cover approximately 50 percent of the small group market, all of which have the benefit of managed care programs.

At Blue Cross and Blue Shield, we share your concern about the problems faced by small employers in purchasing health insurance. Last year, the state of Connecticut enacted legislation (P.A. 90-134) in response to these same concerns. I am appearing before you today to discuss this legislation and its impact on Connecticut and the potential of this legislation as a model for action for other states.

My testimony today will begin with a discussion of the problems in the small group health insurance market. I will then discuss the extent to which Connecticut's legislation addresses these problems, and conclude with my thoughts on the usefulness of the Connecticut legislation as a model for action in other states.

Problems in the Small Group Health Insurance Market

The primary problem small employers face in deciding whether to purchase health insurance coverage is one of cost.

The cost problem has, of course, worsened over time, as overall health care costs have escalated. Lack of availability, on the other hand is a relatively recent problem. This problem -- the inability of small employers, particularly those with high-risk, high-cost employees, to obtain health insurance coverage -- is a relatively recent phenomenon, and one that has arisen in response to competitive forces, driven largely by efforts to provide lower-cost coverage to small employers.

Availability of insurance was not an issue when health insurance first evolved. Nor was the use of a small group's own experience in establishing its rates -- a commonly used practice today. When Blue Cross and Blue Shield Plans began providing insurance coverage in the 1930s, every applicant was accepted for coverage, regardless of health status. And all coverage was community-rated -- that is, a small group's own rates were established based on the overall cost of covering the entire insured population, rather than the individual group's own health status or experience. In this way, the cost of coverage for groups with the poorest health risks was kept at the most affordable level possible, because lower-risk enrollees heavily subsidized the costs of higher-risk enrollees, or, from a demographic perspective, the younger, healthier insureds subsidized the older, sicker insureds.

Competition then entered into the health insurance market and underwriting practices emerged similar to those traditionally used in other lines of insurance, whereby small group rates are varied according to the risk or experience of particular small groups with coverage denied for groups with pre-existing conditions. And, in addition to being very selective in the risks they will accept, some insurers also refuse to renew coverage of groups that have high claims experience, leaving such groups uninsured, and probably uninsurable in a restricted access competitive market environment.

These changes came about in part because of employers' demands for lower prices. As health care costs escalated, employers began to resist provider and payor efforts to distribute costs among insured groups through such mechanisms as community rating. Demands for lower premiums and an end to cross-subsidies led many insurers to select and rate groups based on risk through the use of demographic and/or experience

rated approaches. This shift has brought insurance costs down for many employers, but it has exacerbated the affordability problem for a growing number of small employers, especially those who remain in community rated programs.

In this competitive environment, it became increasingly difficult for carriers to accept all applicants and maintain competitive prices. For this reason, many carriers that previously accepted all comers and community rated that coverage have had to move away from those practices. Many carriers now reject high-risk groups and rely in varying degrees on a group's own experience to set its rates -- a practice which results in competition for the better risk groups and high costs for the poor-risk groups.

In spite of the changes in the competitive environment, some carriers have maintained their early practices. Blue Cross and Blue Shield of Connecticut generally has not used medical underwriting to identify and deny coverage to high-risk small employers. Nor have we ever used a small group's own experience or health status to establish its rates. We have continued to community rate our small group products, although we have had to move away from pure community rating by adjusting our community rates to account for a small group's demographic characteristics, because of competitive pressures. The more aggressive practices of our competitors enabled them to skim off our good-risk groups, resulting in an adverse selection spiral in our business.

With the passage of P.A. 90-134 last spring, we have been forced to adopt medical underwriting in order to assess properly the risk of small group applicants for the purpose of participating in the private reinsurance pool mechanism. This represents a significant change in the inherent way Blue Cross and Blue Shield of Connecticut does business. However, it is a necessary requirement for our corporation if we are to continue to offer coverage to the small group market under the new legislation. I also would note that as a result of this legislation, we will begin adjusting small group rates to reflect their underlying risk or experience, within the limits allowed under the new law.

Connecticut's Legislation

Last May, in response to the perceived problems of availability and affordability of insurance coverage for small employers (size 1-25), Connecticut adopted legislation that establishes the following:

- Standards of behavior for carriers in the small group market. Carriers must accept all applicants for coverage, are prohibited from dropping small employers from coverage because of bad experience and must limit the use of a group's own health status or experience in determining its rates.

- A Mandatory Reinsurance Pool. A mandatory, private reinsurance program will be established to spread the costs associated with accepting all small groups on a guaranteed issue basis. Losses from the reinsurance mechanism will be financed first from the small group market and then through the rest of the private insured market.

- Lower-Cost Products for Currently Uninsured Small Groups. Currently uninsured small groups will be able to buy a special lower-cost product from all carriers, provided the groups have not had coverage for the period two years prior. The lower cost is achieved by establishing provider reimbursement at 75 percent of Medicare rates. Another provision will prohibit providers from balance billing insureds whose income level is below 200 percent of the poverty line.

- Expanded Public Programs for the Low-Income. The legislation also provides for a variety of new programs, both Medicaid expansions and direct service programs, for low-income individuals.

Comments and Concerns with the Connecticut Legislation

In evaluating the utility of this legislation as a model for action in other environments, it is important to understand what the legislation will and will not do in Connecticut. For that reason, I will turn now to a discussion of the legislation's effect on the goals of improving affordability and availability.

**Effects on Affordability.** The initiatives to establish lower-cost products and extend public program coverage for some small employers are designed to address the affordability problems faced by most small employers. However, we have grave concerns about using 75 percent of Medicare payment rates. The cost shift resulting from inadequate Medicare and Medicaid payment rates in Connecticut totaled $650 million last year. And we project that by 1993, the average shortfall per hospital admission for a publicly funded patient will be $2,666. In Connecticut, Medicare and Medicaid beneficiaries account for about half of all hospital admissions; the other half are private patients. This means that the private sector -- small and large businesses alike -- will pay on average $2,666 more per admission than the public programs. This is significant! Our concern is that unless public funding of these entitlement programs is improved, this legislation will exacerbate the affordability problem already faced by small employers that currently provide health insurance coverage.

In the interests of containing costs, Blue Cross and Blue Shield of Connecticut supports exempting all products sold to small employers from state mandates -- which can add up to 15 percent to the cost of coverage for small employers in Connecticut. This exemption was not included in the legislation. As a result, many small employers will continue to face increased costs related to state mandated benefit and provider laws -- which, while providing meaningful coverage, do not necessarily allow for flexibility in assuring affordable coverage. In addition, it is important to understand that the carrier reforms and the mandatory reinsurance program probably will result in increased costs for many small employers, for the following reasons:

- The rating reforms will require carriers that currently use experience rating to narrow the range of rates charged to small groups so rates for groups with similar demographic characteristics could not vary by more than 200 percent. This will lower rates for some high-risk groups, but will increase rates for lower-risk groups.

- The guaranteed issue requirement, in combination with the reinsurance pool mechanism, will distribute the costs of covering high-risk groups throughout the market, once again resulting in potentially higher rates for lower-risk groups, in comparison to current rates.

- The lower-cost plans for uninsured small employers are intended to address the affordability barrier that prevents many small employers from buying coverage. However, we are not very optimistic about the ability of these lower-cost plans to significantly reduce the number of uninsured small groups. While the program initially will lower the cost of health insurance for these small employers, its availability is limited to a three-year period. A better way to assure the

availability of lower-cost coverage would be to remove state mandates. We believe any future legislative initiatives dealing with this issue must consider how to assure cost effectiveness and avoid additional cost shifting.

- The overhead costs associated with implementing and administering this complex new reinsurance program also will increase the cost of small employer coverage. At our initiative, the Board of Connecticut's reinsurance mechanism, on which we serve, recently suggested changes to the program's design that will simplify its administration. The insurance commissioner approved these changes and the Board's revised plan of operations on February 1st. I believe this effort significantly improves the reinsurance mechanism's viability. However, areas of complexity remain.

**Effects on Availability.** One of the noted objectives of the legislation is to assure that all small employers have access to private insurance coverage and to shift the basis of competition away from risk selection practices. To meet this objective, the legislation requires all carriers in the small group market to accept all small groups for coverage, and it establishes a mandatory, private reinsurance mechanism to help carriers manage this requirement. While we will continue our efforts to make the legislation adopted here in Connecticut work as well as possible, I do feel there are alternatives that would simplify and improve the overall approach of assuring the availability of private coverage to the small group market.

I should note that availability of private coverage for small employers has not been a problem in Connecticut. Because of the practice of Blue Cross and Blue Shield of Connecticut as well as those of some other carriers, coverage generally has been available to any small group.

And, while one goal of the legislation is to move carriers away from risk selection practices, the legislation in fact encourages continued use of risk selection. This result will occur because carriers must use medical underwriting to identify which small groups to reinsure, because all carriers -- including our Plan -- are required to participate in the reinsurance program. Consequently, the legislation has forced us to adopt the practice of medical underwriting for purposes of identifying which groups to reinsure, to appropriately adjust rates, within the prescribed bands, to remain competitive in the market.

Problems with Using Connecticut as a Model

While Blue Cross and Blue Shield of Connecticut has focused its efforts on trying to make the new legislation work for the small group employees of our State, we continue to believe that it is premature to state that this legislation represents the best -- or even the preferred -- solution to the problems in the small group market from a national perspective.

The legislation fails to do enough to address the key problem of costs, and fixes an availability "problem" that wasn't a problem with an administratively complex and expensive new reinsurance program.

In addition, some of the design elements included in the Connecticut legislation may be problematic if adopted in other states.

**Voluntary v. Mandatory Carrier Participation.** One key design element is whether all carriers should be required to participate in the reinsurance mechanism, as in Connecticut. While we do not oppose the mandatory design

of the reinsurance mechanism here in Connecticut, we recognize that some Blue Cross and Blue Shield Plans and HMOs in other states would prefer a voluntary approach. In such states, we believe it would be appropriate to permit these carriers to opt out of the reinsurance program, as long as they accepted all small groups for coverage and met the same rules as other carriers with respect to their rating and renewal practices. A voluntary approach would avoid the problem of forcing carriers to adopt medical underwriting in order to remain competitive. It also would reduce the number of high-risk groups covered through the reinsurance mechanism -- and therefore the subsidy necessary to support program losses.

**Volume/Assessment Structure.** Another key design element is the volume of claims covered by the reinsurance mechanism -- and, correspondingly, the assessment mechanism used to finance program losses. These two issues are inextricably linked, because the higher the volume of claims paid by the new mechanism, the larger the losses that must be financed.

The assessment structure in the Connecticut legislation relies first on the small group market and then on the large group and individual markets. A key concern with this structure is the inequity of assessing insured larger group business when ERISA will protect self-funded larger groups from helping to finance any program losses. We believe that any assessment beyond the small group market should be as broad-based as possible. Another important design consideration is how much of the risk associated with accepting all small groups is retained by individual carriers versus spread to the rest of the market. This decision is important both because of its implications for incentives to manage the care of high-cost cases and the need for assessments to finance pool losses. We believe it is critical for any reform effort to assure carrier accountability in accepting and managing risk and to encourage cost containment efforts.

**Administrative Complexity.** The degree of administrative complexity -- and cost -- involved in establishing and operating a reinsurance mechanism as defined in Connecticut continues to be a major concern for us, and will be a concern for any state considering adopting a similar approach. For this reason, we believe that states should have the flexibility to adopt less complex approaches, if such approaches meet the needs of their environment.

Conclusion

Since passage of the legislation, we have been working with others to suggest needed improvements to the reinsurance program. But, given the untested nature of this program, and the need -- already demonstrated -- to make significant changes in the original program design, we believe it would be inappropriate to view this legislation as a model that should be adopted in other states or, indeed, as a national model. In addition, while the general approach taken in Connecticut may be appropriate in some other states, the issues outlined above demonstrate the need for each state to be able to determine what approach would address most appropriately the nature and scope of the small group problems present in their environments.

For example, there are many other states that have Blue Cross and Blue Shield Plans that already provide coverage to all small employers, regardless of health status. In such states, additional intervention to assure availability of coverage clearly is unnecessary, although it may be desirable to adopt rating and renewal reforms throughout the market. And in states where availability is a problem, states may wish to consider approaches other than the one adopted here, or may wish to modify our approach.

The interim report of the industry advisory committee appointed by the National Association of Insurance Commissioners (NAIC) to develop responses to these problems also reflects the need for state options. Rather than focusing on a single model, the committee's interim report to the NAIC describes six options that are under consideration.

In conclusion, Blue Cross and Blue Shield of Connecticut believes that changes are needed in many states to assure small employers access to private coverage at fairly determined rates. However, our own experience with small group reform legislation suggests that the approach adopted here in Connecticut may not be appropriate in other states.

As your committee debates further how best to address the problems in this market, we ask you to consider the untested nature and the complexity of small group reform proposals, as well as the different environments in different states. We believe that this situation necessitates state flexibility to experiment with different approaches, and we urge you to reject a single-solution approach to this very complex and variable problem.

Thank you again for the opportunity to testify today.

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Mr. DONNELLY. Thank you, Mr. Torello.
Mr. Paydos.

**STATEMENT OF CHARLES J. PAYDOS, EXECUTIVE VICE PRESIDENT, PHOENIX MUTUAL LIFE INSURANCE CO., ENFIELD, CONN., ACCOMPANIED BY JOAN HERMAN, SENIOR VICE PRESIDENT**

Mr. PAYDOS. Thank you, Mr. Donnelly, and good morning, committee members.

My name is Chuck Paydos, and I am executive vice president of Phoenix Mutual Life Insurance Co., and head of the company's group line of business.

I am especially pleased at the opportunity to speak to you today because you are addressing one of this country's most crucial problems.

The issue of health care coverage is a matter of extreme importance to every citizen, and it is also a matter of deep concern for anyone who runs a business of any size.

I have a very short time to speak to you today, and I have really three points to make.

First, this is not just a matter of access that we are dealing with; rather, we think primarily it is a matter of affordability.

Second, we recognize that changes need to be made, and we not only recognize this, but we have been very active in those processes that will promote change.

And, third, we believe that the problems should be solved at the State level rather than to impose a single Federal solution.

Now, allow me to amplify these points. Regarding my first point on the issues of access and affordability, the 30 years that Phoenix has specialized in the small employer marketplace, we know these businesses, their owners and their employees. They are our clients. For 30 years, our survival has depended upon our listening very carefully to these people, and we have found that they face unique problems.

Small companies are struggling to do the right thing, to protect their employees, but in the process, because costs are high, they are straining their ability to compete, and even in some cases to stay in business.

As I said, the problems are twofold, access and affordability. When you are dealing with issues of access, you must remember that 85 percent of Americans have some form of insurance, private or government sponsored. It is the other 15 percent who need our help.

Our company and our industry are intent on helping devise a way to provide coverage for that 15 percent, but, and I cannot stress this enough, any solution must not jeopardize the programs that already are working for 85 percent of the people.

When we talk about the problems facing the typical employer, the typical small employer, we find that affordability is always at the top of the list, the biggest impediment to sponsoring an employee benefit plan.

It is a fact that many small employers in Connecticut and elsewhere provide no health insurance or other employee benefits be-

cause they simply cannot afford to, and it is a fact that small companies shop their coverage year after year, and it is a sad fact that many have dropped their health insurance coverage when faced with yet another rate increase because they simply cannot afford it.

The pressures on this segment of the market are increased by the spiraling costs of health care, which have climbed faster than the rate of inflation for more than a decade. They reflect not only increased charges by hospitals and doctors but also the increased use of medical services, expensive advances in technology, and a shifting of costs from the public to the private sector.

The premiums must reflect the level of benefits being paid out. If health care costs rise, premiums rise, and all of this is the reality of the small employer marketplace that we work in at Phoenix, but not only is the cost of the health care a direct problem for employers; it is also a difficult market for insurance companies themselves to do business.

Regarding my second point, the need to change, we have been active. Our representatives at Phoenix have served on a National Association of Insurance Commissioners' Advisory Committee, Health Insurance Association of America committees, and closer to home, we have worked hard with members of the Insurance Association of Connecticut to develop a workable proposal, and we have also tried to make our views known in government forums at the State and Federal level as we are doing today.

Having said all that, and regarding my third point, I must tell you that it is premature for the Federal Government to mandate a specific small group solution to all the States, and here is why.

The vast majority of States are already moving to deal with the issue of improving access to health care. In fact, there are a variety of solutions being proposed at the State level, and it is not at all clear which will be the most effective.

Just last year, nine States passed laws allowing lower cost policies without mandated benefits. Four States adopted rate limits on companies. The NAIC has adopted model proposals that we expect many States to seriously consider this year. In addition, the HIAA has developed a very specific proposal that deals with, among other things, rate reforms and guaranteed availability and provisions for continuity of coverage, and the industry is supporting that proposal.

We expect many States to pass legislation this year, in fact. We believe it would be far better to allow the States to become laboratories trying different solutions to see which works best. We should reach some conclusions within 3 to 4 years.

And there is another reason for caution. The problems are extremely complex. So it is difficult for even highly knowledgeable people to find effective solutions. We have already seen this here in Connecticut, where it has become apparent that some changes in the existing law may be needed.

Finally, because of the critical nature of the problem, it is essential that the Federal Government not leap to a solution that in the end makes the situation worse. Premature mandating of a specific single program could do irreparable harm to the small group

health insurance market, driving up the price and diminishing capacity.

We would like to encourage States to improve access to health care, so we suggest that the Federal Government encourage the States to adopt programs to improve access, including permission to sell health insurance plans free of mandated benefits.

In addition, there should be an expansion of tax credits and incentives for self-employed and small employers to provide coverage for their employees.

We in the insurance industry will do our part by guaranteeing access through the use of reinsurance pools in order to assure that all small employers will be able to provide a basic level of benefits to their employees.

But in conclusion, I come back to the matter of affordability. While the programs that we have discussed guarantee availability, they only begin to address the problem of affordability which continues to be the chief cause of noncoverage, and to solve this problem, we simply have to drive down costs or at least constrain the rapid increase.

But the Federal Government cannot solve the problem alone. The insurers, small businesses, health care providers and individual employees cannot do it alone either. We simply must work together cooperatively to find that critical balance to protect the health of all the country's citizens.

In holding these concerns, I know you recognize that need, and I assure you that we recognize it as well.

Thank you.

[The prepared statement follows:]

**Testimony of**

**Charles J. Paydos, F.S.A.**
**Executive Vice President, Phoenix Mutual Life Insurance Company**

**before the**

**Subcommittee on Health, Committee on Ways and Means**
**U.S. House of Representatives**

**February 25, 1991**

Good morning, Chairman Stark and members of the Committee. Myname is Charles Paydos and I am Executive Vice President of PhoenixMutual life Insurance Company and head of the company's Group lineof business.

I am especially pleased at the opportunity to speak to you today, because you are addressing one of this country's most crucial problems. If pocketbook issues are becoming increasingly important, I can't think of an issue that affects everyone's pocketbook to the extent that this one does. . . an issue that literally affects the lives of every citizen in this country. The issue of health care coverage is a matter of extreme importance to every citizen. It is also a concern for anyone who runs a business of any size. And obviously, it is critical to those of you who are elected to govern this country and who must make sense out of an incredibly complex and difficult problem.

My company, The Phoenix, is a life and health insurance company. We are a mutual insurance company, which means that our only owners are our policyholders. The Phoenix provides health care coverage to over one million people working in businesses across the country. The vast majority are small businesses with fewer than 25 employees. For 30 years, The Phoenix has specialized in this market . . . the small employer market.

We know these businesses, their owners and their employees. They are our clients. . . and we've found that they face unique problems. Small companies are struggling to do the right thing, to protect their employees. But in the process, they are straining their ability to compete. One more dollar, one more dime in health care costs places a small company's capital reserves and discretionary dollars, its financial livelihood and its workforce at risk.

The problems are twofold: Access and affordability. When you're dealing with issues of access, you must remember that 85 percent of Americans have some form of insurance, private or government-sponsored. It's the other 15 percent who need help. Our company and our industry are intent on helping devise a way to provide insurance for that 15 percent, but, and I cannot stress this enough, any solution must not jeopardize the programs that already are working for 85 percent of the people.

When you look at the problems facing the typical small employer, affordability is at the top of the list, the biggest impediment to sponsoring an employee health plan. And make no mistake about it. It's a fact that many small employers in Connecticut and elsewhere provide no health insurance or other employee benefits. It's a fact that small companies "shop" their coverage, year after year. And it's a sad fact that many have

dropped their health insurance coverage when faced with yet another rate increase because they simply can't afford it.

The pressures on this segment of the market are increased by the spiraling costs of health care, which have climbed faster than the rate of inflation for more than a decade. They reflect not only increased charges by hospitals and doctors, but also the increased use of medical services, expensive advances in technology and the shifting of costs from the public to the private sector.

That's the reality of the marketplace. This is the reality of insurance, the business I work in: Premiums must reflect the level of benefits being paid out. If health care costs rise, premiums rise. But not only is the cost of health care a difficult problem for employers, it also creates a market in which it is difficult for insurance companies themselves to do business.

Let's put it bluntly: We have not made money selling health insurance. Over the last 20 years, The Phoenix has seen an accumulated net loss of 3.7 percent of premium in group health insurance. The good years have been more than offset by some terrible years. The aggregate loss has been countered by selling other types of group coverage. But even with these additional sales, our total profit margin in our group business has been only 3.3 percent of premiums over these 20 years.

We remain in the market because we are committed to providing benefits to small business. As I've said before, they are our primary clients.

Because of this commitment, The Phoenix has actively participated in debates nationwide discussing the problems of the uninsured, particularly in the small group market. Our representatives have served on a National Association of Insurance Commissioners Advisory Committee, Health Insurance Association of America committees and, closer to home, have worked with members of the Insurance Association of Connecticut to develop a workable proposal.

Having said all that, I must tell you that it's premature for the federal government to mandate a specific small group solution to all the states, and here's why:

The vast majority of states are moving to deal with the issue of improving access to health care. In addition, there are a variety of solutions being proposed at the state level and it's not at all clear which will be the most effective.

Just last year, nine states passed laws allowing lower-cost policies without mandates. Four states adopted rate reforms. The NAIC has adopted model proposals that we expect many states to seriously consider this year. And more than 40 states are looking at ways to deal with the issues of access and affordability for small businesses. We expect many of them to pass proposals this year. In addition, the HIAA has developed a very specific proposal that deals with, among other things, rate reforms, guaranteed availability and provisions for continuity of coverage, and the industry is supporting that proposal.

We believe it would be far better to allow the states to become laboratories trying different solutions to see which works best. We should reach some conclusions within three to four years.

There's another reason for caution: The problems are extremely complex, so it's difficult for even highly knowledgeable peop' to find effective solutions. We've already seen this here in Connecticut, where it has become apparent that some changes in the existing law are needed.

Finally, because of the critical nature of the problem, it's

Finally, because of the critical nature of the problem, it's essential that government not leap to a solution that in the end makes the situation worse. Premature mandating of a specific program could do irreparable harm to the small group health insurance market, driving up the price and diminishing capacity.

We want to encourage states to improve access to health care, so we would suggest that the federal government encourage the states to adopt programs to improve access, including permission to sell health insurance plans free of mandated benefits. In addition, there should be an expansion of tax credits and incentives for self-employed and small employers to provide coverage for their employees.

But I return to the matter of affordability. While these programs that we've discussed will guarantee availability, they only begin to address the problem of affordability, which continues to be the chief cause of non-coverage. To solve the problem of affordability, we simply have to drive costs down.

But the federal government cannot solve the problem alone. The insurers, small businesses, health care providers and individual employees cannot do it alone, either. We simply must work together, cooperatively, to find that critical balance to protect the health of all this country's citizens.

In holding these hearings, I know you recognize that need and I assure you that we recognize it as well. Thank you.

Chairman STARK. Thank you.
Mr. O'Brien, would you like to enlighten us?

**STATEMENT OF G. ROBERT O'BRIEN, EXECUTIVE VICE PRESIDENT, CIGNA CORP., HARTFORD, CONN.**

Mr. O'BRIEN. Good morning, Mr. Chairman and members of the committee.

I am Bob O'Brien, president of the CIGNA's Employee Benefit Cos.

Now, CIGNA is the largest investor-owned commercial health insurance operation in the United States and one of the largest operators of HMOs.

My purpose here this morning is to encourage congressional support for the managed care approach to constraining health care costs while delivering quality of care.

I would call for your endorsement of efforts designed to encourage the use of managed care in the private and in the public sectors. I would suggest that you take steps to prohibit activities that are designed to limit the development of managed care concepts.

It is my understanding that legislation such as this will be on the floor in the near future.

Let me say at the outset that CIGNA believes that all Americans should have access to necessary health care. We believe that this goal can best be accomplished through a public-private partnership with Government providing the necessary assistance for persons who cannot afford private health insurance and for the private sector providing necessary financing and care for the remainder of the population.

Anyone who is committed to providing universal access to coverage must recognize that the ultimate success hinges on the ability to control health care cost inflation. We believe that managed care offers the best promise for effecting permanent cost containment.

In CIGNA's experience, managed care has cut the rate of inflation on our health care programs in half. Over the last 3 years, costs under our indemnity programs has been escalating at an average of 20 to 24 percent a year. The rate of escalation under our managed care programs has been less than 12 percent. Managed care is demonstrating that it can effectively control costs in a growing number of situations, and it has the potential to do so on a broader basis.

As we define, Mr. Chairman, managed care consists of health benefit programs that deliver quality of care at lower cost by establishing a carefully selected network of doctors, of hospitals and other providers who are under contract and who agreed beforehand to meet certain predetermined standards of quality and the costs that they would charge for these.

It must also include incentives for the individuals in the system. At the heart of the managed care network is the primary care physician, a care manager doing exactly what general practitioners of the traditional family medicine were trained to do; that is, diagnose and coordinate the treatment while building strong relationships with the patients and their families.

But there is a difference. This new generation of physician manages a patient's entire medical care, controls specialist referrals, authorizes hospital admissions, monitors for quality, and works with the overall team to ensure the most effective medical care delivery.

To critics who say managed care does not work, let me say that they have not implemented a program of managed care yet. They have been flirting with a few of the techniques of managed care. The real potential for savings lies in achieving lasting change in behavior through contractual relationships established with a limited number of primary care physicians and specialists.

It is very clear to me that based on our experience of the last several years, that managed care is having an impact on the costs and ensuring the delivery of quality care.

All too often, efforts to develop managed care arrangements are considered constrained by ill-conceived State legislation and some outdated Federal regulations. Impractical shackles placed on cost containment programs are destructive and inflationary.

In addition, we would urge that you set the health policy of this country through the use of managed care networks for both public and private programs.

We believe that the network-based incentives and the case management techniques that work in the private sector will work for Medicare and for Medicaid. Other Government programs, such as those covering Federal employees, the military and veterans, could also make more extensive use of network-based managed care programs. The potential savings is huge.

I appreciate this opportunity. Thank you, Mr. Chairman.

[The prepared statement follows:]

Testimony of G. Robert O'Brien
CIGNA Corporation
Before the Subcommittee on Health
House Committee on Ways and Means
Hartford, Connecticut
February 25, 1991

Good morning, Mr. Chairman. My name is Bob O'Brien. I am Executive Vice President of the CIGNA Corporation. CIGNA is the largest investor owned commerical health insurance operation in the country and one of the largest operators of HMOs. Our premium volume now exceeds $16 billion. We cover some 13 million people, operate more than 70 managed care networks and have contracts with over 25 thousand physicians. Over the past several years we've had a number of very successful experiences with our growing managed care operations and I want to take the opportunity this morning to share those experiences with you.

My purpose this morning is to encourage Congressional support for the managed care approach to constraining health care costs. I would call for your endorsement of efforts designed to encourage the use of managed care in private and public health care programs at both the Federal and state level, and to suggest that you take steps to prohibit activities designed to limit the development of the managed care concept. It is my understanding that legislation addressing these issues will be introduced in the near future, and I would urge that it be given full consideration as an important element in addressing our nation's health care challenge.

Let me say at the outset that CIGNA believes all Americans should have access to necessary health care. We believe that this goal can be best accomplished through a public/private partnership with government providing the necessary assistance for persons who do not have access to privately financed health care services. This system has provided the vast majority of Americans with the best health care in the world for almost eighty years.

We strongly support enactment of reforms that would help to stabilize the small employer financing of health services and make coverage more readily available to all employers. However, these and other reforms cannot be addressed in a vacuum. Anyone who is committed to providing universal access to coverage must recognize that the ultimate success hinges on the ability to control health care cost inflation.

We believe managed care offers the best promise for effecting permanent cost containment.

Eastern Europe offers a fine example of the economic consequences in the absence of a private competitive market. And in those countries, such as England and Canada where a federalized health system has existed, costs have risen dramatically.

Managed care, on the other hand, is designed to encourage both the patient and the provider to effect lasting changes in behavior of both parties through the use of incentives to reduce unnecessary use of the health care system and cost, while still delivering quality care. In fact, managed care encourages quality and it's working as a means of constraining costs.

In CIGNA's experience managed care has cut the rate of inflation in our health care programs by one-half. Over the past three years, costs under our indemnity programs have been escalating at an average of 24%. The rate of escalation under our managed care programs has been less than 12%. Managed care

is demonstrating that it can effectively control costs while delivering quality service in a growing number of individual care situations. It has the potential to do so on a much broader base.

What is Managed Care?

Managed care is a term that is frequently misunderstood. Managed care is basically a health care delivery system; a way in which people get their health care. Financing health care costs can be done in a variety of ways -- through payroll taxes, through Medicare, through tax rebates, employer based premiums, and so forth. Managed care is the delivery component that can fit with any of these financing mechanisms. As we define it, Mr. Chairman, managed care consists of health benefit programs that deliver quality care at lower cost by establishing a carefully selected network of doctors, hospitals and other providers who are under contract and who agree beforehand to meet predetermined standards of quality and costs for the care they give. It also must include incentives for individuals to use network physicians.

At the heart of the managed care network is a primary care physician -- a care manager doing exactly what general practitioners of traditional family medicine were trained to do: diagnose and coordinate treatment while building strong relationships with patients and families. But there's a difference. This new generation of physician manages a patient's entire medical care, controls specialist referrals, authorizes hospital admission and monitors for quality.

To critics who say "managed care doesn't work", let me say they haven't implemented a program of managed care yet. They've been flirting with a few of the techniques of managed care. Techniques such as utilization review, second surgical opinion and procedure review can have a positive impact and should be encouraged, but they are only techniques and should be present in all plans. The real potential for savings lies in achieving lasting change in behavior through contractural relations established with a limited number of quality physicians.

A good example of what managed care can do is the program we created and administered for Allied/Signal. A reference to this plan was included in the President's Budget message on February 4th. Through this arrangement we have reduced the cost of financing health services $750 per employee per year, while maintaining high levels of quality care. The figures on hospital usage are particularly impressive in relation to our indemnity business. By precertifying hospital admissions and carefully monitoring each patient's progress, noteworthy results have been achieved. Specifically:

| | Allied | Typical Indemnity |
|---|---|---|
| Admission Rates per 1000 | 57 | 77 |
| Average Length of Stay(days) | 4.6 | 7.3 |
| Bed days per 1000 | 271 | 562 |

Allied-Signal saved more than $200 million over a three year period.

I am happy to report that both companies have found this approach productive and are continuing this relationship. The news release from Allied on this subject indicated their continuing satisfaction with the program. It's a tough program, but Allied employees have adjusted to it, use the network physicians in excess of 95% of the time, and get excellent care.

Of course, Allied's benefit plan characteristics are unique to Allied, and other employers may have more difficulty generating savings of this magnitude if they are unwilling to take the same bold steps as Mr. Hennessy, Allied's CEO, did. But suppose all U.S. employers who finance health care services were to adopt such aggressive cost-management tools. Suppose they could save $75 per employee, just a tenth of

Allied-Signal's savings--$750 per employee over a year--by adopting well-conceived and well-communicated managed care programs. Even with this very conservative estimate, the private sector could save more than $10 billion. My personal belief is that such savings could approach $30 billion. To substantiate my belief, I refer you to the recent estimates by Dr. Robert Brook of the Rand Corporation who indicates that approximately $50 billion of unnecessary services are delivered each year.

It's very clear to me, based on our experience over the last several years, that the managed care carriers are adding real value to the health care system. We compete vigorously to develop the best networks and to negotiate the best prices for our customers and we've developed the cost containment techniques to meet those price commitments. As importantly, we've introduced measures to monitor quality that could never exist in the fee-for-service system. Patient satisfaction surveys, development and review of individual physician practice patterns, physician-to-physician counselling and, when appropriate, removal of physicians from our networks, all of these activities are integral to managed care.

Managed Care Programs for Small Employers

While the publicity of the success of managed care has been focused on large employers such as Allied/Signal, I am pleased to report, Mr. Chairman, that small employers are taking advantage of managed care as well. We cover many small employers either directly or through various association programs. For example, in Los Angeles, we have over 25,000 covered lives in our HMOs through one such program. Through our Direct Marketing Division, we recently have completed negotiations with American Express to jointly market a CIGNA managed care product utilizing our HMO networks to small employers in markets where a CIGNA HMO network currently exists. We also are working with additional sponsors to expand this market substantially. We expect to be successful and expect other companies to follow suit.

Through our new business ventures we think we will be making substantial progress toward solving the small employer health care coverage dilemma.

Regulatory Barriers to Competitive Health Care Systems

A critical role for government to play in health care at both Federal and state levels should be to assure that regulation and incentives are carefully balanced -- encouraging affordable private insurance plans and effective managed care systems. All too often today, efforts to develop managed care arrangements are severely constrained by ill-conceived state legislation and outdated Federal regulations. Impractical shackles placed on cost containment programs are destructive and inflationary.

Financing entities should be allowed to provide low-cost indemnity benefit programs and a complete range of managed care programs. To accomplish this end, state mandated benefit requirements and unreasonable state restrictions on managed care plans should be eliminated. Here's where Congress can play a constructive role in establishing a national framework which will allow the private sector to respond to consumer needs.

We have identified a number of laws in the various states which pose a barrier to managed care including ones that limit the development of effective networks and ones that restrain effective utilization review programs. Examples include laws and regulations that:

- Restrict the ability of third-party payors to negotiate the form and rate of reimbursement with providers and require them to reimburse providers based on reasonable, customary and necessary charges determined by the providers; these laws restrict the ability of managed care plans to develop cost-effective care;

- Require a managed care plan to pay the same fees to providers who are not included in its system as those who are; this requirement destroys the incentives necessary to develop a managed care system and undermine its purpose;

- Restrict the rights of sponsors of managed care plans to contract selectively with a limited number of providers; this limitation prevents managed care plans from contracting with providers who meet their practice standards;

- Restrict the right of plans to utilize primary care physicians in a gatekeeper role; these restrictions limit plans' ability to ensure that appropriate and cost-effective treatment is provided;

- Limit the co-payment that a managed care plan may require a beneficiary to pay when a non-plan provider is used; these limits undermine the ability of a plan to give sufficient incentive to patients to use the network of cost-effective providers;

- Prohibit utilization review of certain treatments or conditions; these prohibitions gut a critical element of managed care;

- Require utilization review decisions to be made by residents of the state in which the treatment is offered; these requirements make it difficult for national companies to participate in the local market and add unnecessary costs.

These artificial barriers frustrate our ability to meet consumer demand for managed care programs and deprive the nation of the savings and quality assurance associated with managed care.

Managed Care for Government Programs

A second critical role for government is in the area of contracting for its own beneficiaries and employees. We would urge you to set the health policy direction for the country through the use of managed care in government programs. An obvious but major step would be to improve the efficiency of Medicare and Medicaid through managed care. Medicare and Medicaid have employed utilization review techniques for a number of years and have used HMOs in a very limited fashion.

The current program of HMO Medicare Risk Contracts doesn't pass muster in the marketplace. It relies on individual sales and enrollments (and we've seen how that may cause problems) and fails to take advantage of the predominant method of providing health benefits through the employer. The employment based approach offers important consumer protections, lower costs, economy of scale, and has the potential for real dramatic growth. We have a whole generation of "managed care" employees who will age back into the costly fee-for-service systems unless you take action.

I would urge you to apply the network based financial incentives and case management techniques that work in the private sector to Medicare and Medicaid as well. Other government programs such as those covering Federal employees, the military and veterans also could make more extensive use of network-based managed care programs. Again, the potential for savings are huge and we want to work with you in developing new approaches.

Clearly, managed care can only succeed as a national alternative if it is broadly implemented. A few cases or even a few hundred cases of substantial size will have a very modest impact in containing costs and modifying physician behavior. On the other hand, if managed care is broadly implemented it will have a major impact on costs and quality. We are aware that at least five of your colleagues either have or will

introduce major health care reform measures. All of these proposals, as far as we know, include provisions to promote the development of managed care through tax incentives, limitation on state restrictions to managed care, or both. We are very encouraged by this movement and would ask your support for managed care as well.

Conclusion

Mr. Chairman and other members, on behalf of myself and my associates from CIGNA Corporation, we thank you for the opportunity to appear before your subcommittee and assure you that we stand ready to join you in your efforts to address the problems facing uninsured Americans.

Chairman STARK. Thank you.

Ms. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman, and thank you all for your testimony, and I particularly appreciate the more specific description of managed care and how it does—how it has the potential to control costs over the long-term on a continuing basis while actually improving the quality of care.

I do want to ask you, since all of you were very much involved in developing the Connecticut model, to clarify some things about that legislation.

It is true that under ERISA anyone who is self-insured does not have to comply with State mandates. I believe it is true that most big employers in Connecticut are self-insured under ERISA and therefore offer a package of benefits to their employees that they select but that are not determined by State mandates.

I believe it is true that the small market, the small business markets, small employers, are the only group that are in a sense totally controlled by State mandates because they do not have the ability to self-insure.

So that makes the issue of State mandates very important. First of all, they are not affecting the care, the design of the plan of the majority of employees, and they are driving up costs.

In your study during the Blue Ribbon Commission, how much would you say they are driving up costs? Someone in their testimony referred to 15 percent. I know some of the plan designs that were considered during the Blue Ribbon Commission deliberations showed that premiums could be cut almost 40 percent if the State mandates could be circumvented, and, so, I would like your further comment on that.

It is important that the Connecticut program does not relieve the small business sector of State mandates, although the large business sectors already are out from under State mandate, and that instead of controlling costs by relieving from State mandates, they control costs by pegging reimbursements at 75 percent of Medicare reimbursements. That means to the extent to which we underreimburse, you are going to underreimburse more.

I think a little discussion about that solution versus the solution of managed care under a well thought out program is worth a little further comment on your part for the benefit of the panel.

Mr. LEROY. The insurance industry's recommendation going into the Blue Ribbon Commission was to be able to offer small employees a more barebone-type policy without some of the State mandates.

Connecticut has many State mandates. I believe it is the leader in the country, and Blue Cross and the commercial——

Mrs. JOHNSON. Speak a little more closely into the microphone.

Mr. LEROY. Blue Cross and the commercials were united in wanting the option to offer a more affordable policy without certain mandates.

It shows that the give and take of the Blue Ribbon Commission that we were out-voted on that option. In fact, the insurance commissioner in the State of Connecticut was the one who came up with the solution, the compromise, of a lower reimbursement policy with full mandates.

It was not our first choice. However, in the spirit of the Blue Ribbon Commission, we have committed to marketing that plan.

The issue from the provider's standpoint was that while they did not want to get rid of any of the mandates, they were treating these individuals who were coming in on a free-care, charity-care basis. So, the commissioner of insurance said, look, even if we give you a less reimbursement policy, you are going to be getting some reimbursement. Right now, you are getting no reimbursement. This is not going to exacerbate the cost shift. It is going to help the cost shift because you will be getting some dollars in.

That was the thinking behind it, Representative Johnson. It is pegged off 75 percent of Medicare reimbursement levels. It is going to be a much more affordable policy for first-time purchasers. They are only eligible for that for a time certain before they would have to buy full coverage. However, the idea is to somehow get the costs down low enough so that you get the first-time purchasers——

Mrs. JOHNSON. Did I understand you correctly to say that you are only eligible for the more affordable programs for a certain limited period of time?

Mr. LEROY. That is correct.

Mrs. JOHNSON. And then you have to go into the regular market?

Mr. LEROY. That is right.

Mrs. JOHNSON. But the regular market has not been restructured to reduce costs?

Mr. LEROY. Not for the first-time purchaser.

Mrs. JOHNSON. Thank you. Any other comment?

Mr. PAYDOS. Yes. Congresswoman Johnson, the—we think the cost of the mandated benefits by our own work is about 15 to 18 percent of current premiums, and, of course, the elimination of mandated benefits was not part of the Connecticut bill.

The basic benefit policy that was devised, I think, has a prospect of reducing rates by about 30 to 35 percent by our own reckoning.

Mrs. JOHNSON. Thank you.

Mr. O'BRIEN. The State-mandated benefits, the figures quoted are accurate. It is 15 to 20 percent. The problem is that some of the State-mandated benefits really do not fall under the umbrella of health care.

For example, in the State of Connecticut, we cover marriage counselling as a State benefit. For example, hair pieces are covered in the State of Minnesota. For example, in the State of Maine, you cannot use utilization review at all for confinements for mental health or substance abuse because of State-mandated benefits.

So the point I am trying to make is it adds cost to the entire system, and that is why some relief in that could help the small employer because it would make it much more affordable.

Mrs. JOHNSON. Now, would you address also those kinds of benefits, particularly counseling benefits, under managed care? Are counseling benefits available under managed care?

Mr. O'BRIEN. Absolutely, and to give you again some numbers to work with, in a typical indemnity program, mental health and substance abuse costs are about 20 percent of the program.

Hospital days will run between 80 and a 120 days per year per thousand covered, and the managed mental health and substance hospital days are down to 30 and cost is reduced by 60 percent.

Mrs. JOHNSON. But the option is not eliminated when needed?

Mr. O'BRIEN. No, it is absolutely not. In fact, you are getting better service because you are having a medically trained person determining how you should access the system.

Mrs. JOHNSON. Thank you.

Mr. TORELLO. Ms.—I am sorry.

Chairman STARK. Please, go ahead. I am getting ahead of myself.

Mr. TORELLO. We also confirmed that we estimate that the potential reduction as a result of elimination of mandated benefits would be 15 to 20 percent range.

Also, when you talk about the special health care plan, that is a limited program, it is only available for 3 years, it is really a point of entry, but after 3 years, those individuals that have that program are required to go to the open market and purchase one of the standard-type programs.

The other thing we are concerned about, though, is the 75 percent Medicare level reimbursement, represents additional cost shifting, and in our written testimony, I think we identified the fact that we, looking at our own State level of cost shifting, by 1993, we estimate that the average per case cost shift to the private sector will be $2,666.

We think that those are staggering numbers. We think those are driving up expenses, and when you talk about the small group market, there is no other way but through managed care, which is really the means of eliminating unnecessary days of utilization, to cut utilization is the only way that we are going to cut costs, and that has been the driving factor.

I have to agree with Mr. O'Brien because even in the indemnity side, we have made a major push, and we only offer small group coverage with managed care to Blue Cross employees because we do not feel there is any other way for us to contain costs, but we have got to cut utilization in order to cut costs.

The other thing I would like to say, one more thing, is I would think it would also help us if we could start the work product from the bottom up instead of the top down. We all talk about what we should eliminate, but I think it would be more important if we could start with a new base line concept and work a product up and deal with affordability and working the product up.

Everybody is trying to carve out some high base. I would rather start from the base and work up.

Mrs. JOHNSON. Thank you very much. Listening to your——

Chairman STARK. Ms. Kennelly—oh, go ahead.

Mrs. JOHNSON. Listening to—thank you, Mr. Chairman.

Listening to your testimony, you realize that the industry really feels that managed care is the solution for the future.

Do you truly feel that if we put managed care into place as you describe it, that we would not have to do anything else to control costs? Would this be an answer to the whole thing or do you feel we have to continue looking for other ways to control costs?

Mr. TORELLO. What managed care is doing right now is it is dealing with the high cost issue, and what it is attempting to do is to reduce costs by shifting utilization.

What it is going to have to do is it is going to have an impact on the whole medical care infrastructure. So I think if you look at

managed care as being the only solution, that there are going to be some bricks and mortar that are going to start tumbling down because I do think we are going to have a problem within the infrastructure itself. I think it is more than just managed care.

Mr. O'BRIEN. If I may, managed care is not the solution to all the problems. We have got a major problem with access.

The private sector or CIGNA in particular is being very aggressive in marketing to the small employers, but as Blue Cross, we are offering managed care programs because we know it is more affordable and we can accept all of the employees and we do not do a lot of medical underwriting on them.

So I think that we need this partnership that I talked about between the public and private sector to address those individuals that are not employed or are not fully employed to have access to the system which is needed.

Mr. PAYDOS. Beyond managed care, I think that we do need to do more to constrain provider costs. I do not think managed care can do the job alone.

The system is characterized as having excess capacity. We need to try to squeeze some of that redundancy out of the system. Possible sharing different kinds of equipment and perhaps closing down hospital beds. It does seem that the health care system is one industry that does not follow the law of supply and demand. As supply goes up, so does demand and so does price, and work needs to be done there.

It would be wonderful if we could find a way to take some of the large supply of doctors and other providers that we have in the system and get them to work in the areas where there is greater needs, some of the inner cities and so forth and so on. That may be utopia, but we certainly need to do a lot more.

Another factor that has—that looms in prominence, and the way we do business, is provider fraud. I have heard reports that something like 10 percent of the Nation's health costs are tied up in fraud. We need to do more about that.

Insurance companies have to have better ways, be more vigorous in detecting fraud, and we also need help in—from the various governments in prosecuting it. This is becoming a real cancer in our system.

Thank you.

Mrs. KENNELLY. Mr. Chairman, one clarifying point for Mr. Leroy.

Could you tell me why the decision was made to reduce the reimbursement rate below that which Medicare pays providers rather than reducing the number of State mandates? What happened there?

Mr. LEROY. It had something to do, Representative Kennelly, with the politics of the situation.

Mrs. KENNELLY. I want to get it on the record.

Mr. LEROY. Very diverse groups were represented on the Blue Ribbon Commission, including many provider representatives, and there was a lot of good will in regard to trying to come up with something that made sense for everyone.

The issue of reducing mandates simply did not have the votes on the commission. There are, like it or not, a great deal of dollars

behind mandated benefits, and the providers, to be fair, feel very strongly that as specialists in certain areas, they are providing needed care. What occurred was that the votes for reducing for mandates were not there. The insurance commissioner and the providers were saying that they provide this free care. Limited reimbursement was preferable since it restrained the cost shift rather than exacerbating it.

So that was the idea behind it. To sum up, the business community and insurance community were united in trying to offer a more pared-down type policy, but that was not accepted by the membership of the Blue Ribbon Commission.

Mrs. JOHNSON. I will tell you, though, it is one of the things that is looked at when people review it.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Just quickly. Marriage counseling is covered as a mandated benefit?

Mr. LEROY. This year, one of the bills introduced was family therapy.

Mr. DONNELLY. What kind of therapy?

Mr. LEROY. Family therapy.

Mr. DONNELLY. Family therapy.

Mr. LEROY. Which is not necessarily—I do not mean to degrade the counselors trying to offer this. But a health insurance product is supposed to be geared toward medical necessity. What we have seen in State after State is an erosion of that because of the fact that reimbursement drives care.

Mr. DONNELLY. Exactly. I—just quickly, Chuck, I think it is, you mentioned after these two gentlemen testified about managed care, that there is a necessity to do more in terms of reducing provider costs.

Mr. PAYDOS. Yes.

Mr. DONNELLY. Which is music to my ear. Give us some suggestions on what can be done to reduce provider costs.

Mr. PAYDOS. I will try. This is a very large——

Mr. DONNELLY. Well, two or three that come to mind.

Mr. PAYDOS. Off the top of my head, long-term, I think we ought to be trying to constrain the number of physicians that are graduating from medical schools.

Twenty years ago, the—we had a 140 physicians per 100,000 population. I think back then, it was considered we had an adequate supply. Today, the number is 280 per 100,000 population, and that is probably way more than the system needs.

Hospitals still want to have——

Mr. DONNELLY. According to the laws of economics, that should drive prices down, not drive prices up.

Mr. PAYDOS. Unfortunately, it does not. Physician incomes on the inflation-adjusted basis have risen during that period.

Hospitals like to have the latest, most expensive technology right there in their hospitals. It would be nice to see a heck of a lot more sharing. There has been some, there needs to be a lot more.

The same thing that applies to physicians, I think, applies to hospitals. Expensive new wings, wards, a large supply of beds. I do not

think—occupancy rates are not nearly where they were 20 years ago.

We need to do more to encourage hospitals to close down some of their redundant beds. That is a pretty difficult issue to cope with, but I think until we start putting pressure on providers to constrain costs, all this managed care work is not going to——

Mr. DONNELLY. That is the usual top five that we hear.

Well, good luck. I will be watching your divorce rate here very closely. I wish you all well. I hope it does not cost you too much.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Let me just ask a couple of quick ones because we have to move on.

All of you are united in your plea for voluntary pluralistic approach, and I like the way it sounds if it works. I mean that would be my preference.

So let me ask you a couple of questions in that regard.

What is a reasonable standard of success or failure for Connecticut? It seems to me we all have responsibility to set some objectives, and if we fail, try something else. There are now 270,000 uninsured in Connecticut.

Now, what is the reasonable standard of success or failure?

Mr. LEROY. The Blue Ribbon Commission made a couple of the projections. The public sector numbers that were projected if fully implemented was coverage of about 60,000 individuals from the public sector side. Unfortunately, as I think Chairman Stark mentioned, we have some budget problems in the State. The full implementation of the Blue Ribbon Commission plan was pegged at, I think, around $24 million. They only put, I think, somewhere around $2.4 million into it last year.

They did not do projections and, quite frankly, we did not and could not do projections on the impact of the private sector reform.

We are very hopeful. We think that we are going to provide coverage for thousands, if not tens of thousands, of individuals through the private sector reform.

Representative Levin, this is somewhat of an experiment in this State. We will be the first people to tell you we do not know what the total outcome of Connecticut is going to be. We are going to be looking at that measurement very, very closely.

Whether making a dent in half or three-quarters or whatever is a success, I am not sure. That is for policymakers to determine. Yet we believe that out of this plan, we are going to increase coverage for tens of thousands of people in this State, and we think that is something for our little State of Connecticut.

Mr. O'BRIEN. The very specific answer to your question is zero. That is the objective. We want to eliminate it entirely in the State, and I have got——

Mr. LEVIN. When?

Mr. O'BRIEN. I would say over a 5-year period.

Mr. LEVIN. All right. So if it is not reduced to zero within 5 years, you are willing to try something else?

Mr. O'BRIEN. I would say that what we think will work is what is being put in place, and it will be changed as we go through the 5-year period.

Mr. LEVIN. But if it is not down to zero within 5 years, you would be willing to adopt or to support entirely different approach?

Mr. O'BRIEN. Yes. I think what will happen is we move through this 5-year period, what we have in place right now will in fact change probably in the next 2 years and perhaps change again. We do not have the solution. What we have is a group of people who are dedicated to try to find the solution, and as Craig said earlier, we have got something in place, we are implementing it, we think it may work, it has got the support of the community, and our objective is just to eliminate it, and we are going to try hard to do that.

Mr. LEVIN. So you think it is a reasonable target for the proponents of a pluralistic voluntary program in any State to say that in 5 years there should be no people uninsured or something else needs to be tried?

Mr. O'BRIEN. I think if we do not eliminate barriers to access and the cost, we are not doing our job, collectively, both of us.

Mr. LEVIN. Well, let us put it in simple English because we——

Mr. O'BRIEN. Simple English to me is this, very specifically——

Mr. LEVIN. Is 100 percent coverage within 5 years?

Mr. O'BRIEN. Specifically, I think that we need to have the Federal Government's support for the poor and near poor. I think we need the private industry to support all workers, both part-time and full-time. I think we have got to eliminate medical underwriting of individuals. I think we have got to stop on these experience-rated cases that are going up 50 and 60 and 100 percent a year, and I think the industry has got to do that, and we have got to do it in cooperation with the Federal Government to reach those people who we do not have access to in the community.

Mr. LEVIN. By the way, what are your overhead costs, each of the companies here, on health insurance?

Mr. PAYDOS. We are primarily in the small group market. Phoenix Mutual. I am sorry?

Mr. LEVIN. No, no. I know that, but what is the—what is your overhead?

Mr. PAYDOS. Our administrative costs are probably 15 or 16 percent of total premium. Being in the small group market, we do an awful lot of administration and personnel department-type work for the small employer, also provide a lot of compliance advice.

Mr. LEVIN. How about CIGNA?

Mr. O'BRIEN. Our expense ratio is 5.0.

Mr. LEVIN. That includes all expenses——

Mr. O'BRIEN. That includes all expenses on what we call an indemnity book of business.

Mr. TORELLO. Our overall administrative expenses are approximately 8 percent.

Mr. LEVIN. Are what?

Mr. TORELLO. Eight percent.

Mr. LEVIN. Are you two talking the same terminology? CIGNA is 5 percent and Blue Cross and Blue Shield is 8 percent?

Mr. TORELLO. Yes, we are talking about our administrative expenses as a factor of total premium.

Mr. LEVIN. And you are, too? Thanks.

Chairman STARK. Mr. Coyne.

Mr. COYNE. I have no questions.

Chairman STARK. Just a comment because I would not want this subcommittee to go without receiving its just praise.

I have heard a good bit about managed care, but the facts are even on page 10, Mr. O'Brien, of your testimony. You keep mentioning that we need a broad base, and I would presume the broader the better because the Medicare program, which is the largest insurance program in the country, has contained costs. We have got the best record of anybody in the country on our rate of increase.

Now, a lot of people do not like the way we are containing costs, I appreciate that, and it is not pleasant. I mean it takes into account politics, it takes into account our own communities and providers and Mount Sinai having to merge because we perhaps did not pay them enough—there are a whole lot of issues in there, but I have never seen any other way to prevent the shifting unless we have everybody there.

But I wanted then to commend the Connecticut Blue Cross plan because I gather you qualify under what I call the new Rangel law. For those of you who are not aware, if the Blues have no medical underwriting and have open enrollment and community rating, they escape income tax, and for that reason, because we determined that was a socially desirable goal.

If we passed a Federal law that mandated that for all health insurance, there would be no need for risk pools, is that not correct?

Mr. TORELLO. That is right.

Chairman STARK. Is that right, Mr. Torello? You would agree, would you not? I mean really—I have been saying I do not know why we dance around this maypole all the time. If we somehow required all the private insurance companies to be on the same footing, then we would take care of this adverse selection business. I know it would be tougher, but we have some major companies in the country who do that, and I just suggest to you that that is a possibility, and I am curious about this.

You all have talked about some cost shifting figures here this morning, and if there is data you could send us later, I would love to have it because it is—I mean we are comparing lots of apples and oranges as we move around the country, and I would like to get any data that you can send us on this cost shifting, but I would also like to get an idea here.

It is my understanding that the Blue Ribbon Commission has not yet established what the benefits are going to be, is that correct, for this new plan?

Mr. TORELLO. No.

Chairman STARK. They are established?

Mr. TORELLO. They are established.

Chairman STARK. What are they going to be? I mean relative to Blue Cross low option, or Medicare. About where do they——

Mr. LEROY. It is basically a core benefit plan that includes all of the mandated benefits in this State. So it is a very good basic plan.

Chairman STARK. OK. I have Blue Cross low option. Is it more generous than that?

Mr. LEROY. John Troy of Travelers Insurance Co., is the chairman of the reinsurance board of directors.

Chairman STARK. Give me something that I—without having to bore the audience who probably all know about this, but where does it come in relation to a program? More generous than Medicare? Probably.

Mr. TROY. It is a $500 deductible, 80 percent coinsurance plan, with an out-of-pocket limit of, I think, $3,000 per family.

Chairman STARK. Sounds good to me.

What do you think it is going to cost for the under-65 population per person per year? What is your guess?

Mr. TROY. We have a scale of rates, 10-year age bracket. I cannot remember, Congressman. They would probably start in the hundreds of dollars for the young population.

Chairman STARK. Hundreds per month?

Mr. TROY. No. Hundreds per year.

Chairman STARK. Hundreds per year. Any guess?

Mr. TROY. I would have to look.

Chairman STARK. OK.

Mr. TROY. We have a schedule of rates, but probably around $900 up to $4,000.

Chairman STARK. To a couple of thousand. OK.

Mr. LEROY. Congressman, if I might, there are some special provisions in that policy that are geared specifically to low-income individuals, for example, the protection against balance billing.

Chairman STARK. Yes, I understand that. I guess I am trying to compare it with my proposal. We think that we could provide Medicare, you know what the benefits would be obviously, but with a $2,500 out-of-pocket limit and first dollar care for pregnant women and children.

We think we could provide Medicare at $1,000 per under-65 adult, $1,800 per family, or about $400 and change per child, if we just made it available to you at the State. If you wanted to buy it from us, at no cost, and a budget-neutral cost to the Federal Government.

I would be curious to see how you would stack it. We have it age-rated, but that is of interest to us just in how we are going to come out.

I have one final question for Chuck Paydos.

Mr. PAYDOS. Yes.

Chairman STARK. You have indicated in your testimony that you are not making a lot of money on small group health insurance, and I would suspect that it is a marketing tool for other products that you would find profitable.

Do you make money on medigap?

Mr. PAYDOS. We do not offer medigap.

Chairman STARK. You do not offer it. Is there anybody here who sells both that could tell me whether they make—you do. Do you make a higher margin on your medigap than you do on your group or do you——

Mr. TORELLO. No, unfortunately. If we look at our medigap over time, we are probably in the break-even type situation, and life insurance is not a—health insurance is not a 1-year deal. You rise and you fall. Over time, we are almost at a break-even point.

Chairman STARK. On medigap?

Mr. TORELLO. On medigap.

Chairman STARK. On everything?

Mr. TORELLO. On medigap.

Chairman STARK. On medigap. OK.

Would you share some of that—I mean that is interesting because rarely do we find somebody that has that broad coverage. I mean how did you beat Prudential and the AARP? I will not ask that in New Jersey.

Thank you very much. I appreciate——

Mrs. JOHNSON. Mr. Chairman.

Chairman STARK. Oh, I am sorry.

Mrs. JOHNSON. It just might be relevant to this discussion of costs and per month, CIGNA's experience with Allied Signal, and the rate at which you have been able to control costs.

Have those costs increased more or less rapidly than Medicare?

Chairman STARK. And can you tell us what their average costs per employee is or is that secret?

Mr. O'BRIEN. No, I do not think it is secret. I would say we entered into a 3-year relationship with Allied Signal, where the CEO there, Mr. Hennessy, got very aggressive about controlling costs, and their costs went up in single digits when the rest of our business was going up at 20 percent.

It has saved them in excess of $200 million over a 3-year period or it saved them $750 per employee by using managed care networks across the United States because all of the individuals went into it. That is my broad based approach.

The more individuals you get into managed care, the more money you can save, the better treatment you can give, and I would look to Medicare, for example, that there are a host of things you could do to save literally millions and millions of dollars at.

Chairman STARK. Capital. Everybody in Kaiser, and we would save a fortune, but politically we would have a little trouble.

Mr. O'BRIEN. You would have a little trouble. I think you would have a lot of trouble. In fact, when I was testifying to the Pepper Commission, I said that we could guarantee the savings of $30 billion a year, and when I explained that that would mean that all of our senior citizens would probably have to change their primary care physician, they did not——

Chairman STARK. My mother threatened to sleep on a grate before she would join Kaiser.

Mr. O'BRIEN. But we have got to make some of those tough calls.

Chairman STARK. Thank you all very much. I appreciate it, and I look forward to whatever figures you can give us additionally.

[Pause.]

Chairman STARK. The premium rates that were quoted earlier. If we could have those—copies of those for the record later, I would sure appreciate it. Thanks.

Our next panel consists of Renato Ricciuti, representing the AFL–CIO; Jerome Brown, president of the New England Health Care Employees Union, District 1199; Ethan Rome, director of the Connecticut Citizens Action Group; and Janet Spegele, who is the vice president of the Connecticut Business and Industry Association.

I assume that Mr. Ricciuti is going to tell us how he would have voted if he had been the 17th member of the AFL-CIO Commission.

So maybe we would have had a national health insurance plan if his vote counted or maybe we would have had the Kirkland Plan. In any event, Mr. Ricciuti—representing an institution which has been long a leader in bringing health care not only to its own members but to the rest of the country.

We are happy to have you here, and I am going to ask as our guests leave the room or change their seats, out of deference to the court reporter and our panel, if we could hold the conversation down to a minimum. We will then ask Mr. Ricciuti to proceed.

**STATEMENT OF RENATO E. RICCIUTI, COORDINATOR OF RETIRED MEMBERS OF THE COMMITTEE ON POLITICAL EDUCATION, CONNECTICUT AFL-CIO**

Mr. RICCIUTI. Thank you very much, Congressman Stark, Mr. Chairman, and members of the committee.

I am speaking in behalf of the Connecticut State AFL-CIO. At the outset, may I quote from the statement by the AFL-CIO Executive Council on national health care reform? This statement was issued this past Tuesday, February 19.

> We have supported passage of Federal legislation that moves toward the goal of a national social insurance program. We have supported a requirement that all employers contribute their fair share to the cost of care. We have supported the development of a national cost containment system to prevent shifting of costs from one payer to another. We continue to support these principles today and believe that now is the time to renew the fight for a national health care reform legislation consistent with our traditional support of a social insurance program.

The labor movement is united in its determination to achieve universal access, significant cost containment, quality care, and progressive financing. The current crisis, the soaring costs of hospital care, physician services and prescription drugs, 37 million uninsured Americans, mounting threats to quality of health care, and continued strife at the bargaining table demands immediate action.

The refusal of some employers to provide coverage has added to the cost of care for those who are insured while millions of other Americans covered by health plans in the Federal, public, and private sectors have suffered the financial burden of increased cost shifting and reduction in benefits.

The urgency of the health care crisis for consumers and purchasers of care and for those who have fallen through the cracks in the current system requires us to seek relief now without compromising our principles and to support measures that can be enacted.

Such proposals would move the Nation to universal access by requiring all employers, including the Federal Government, to contribute fairly to the cost of care. Such measures also would introduce effective health care costs containment, improve the quality of care, streamline the complex and expensive structure of our current insurance system, and advance the principle of progressive financing.

To succeed in this effort, the federation will form coalitions with consumer groups, employers, community-based organizations, and providers to call on Congress for expeditious enactment of Federal

legislation that will guarantee all Americans the right to health care by establishing a national social insurance program that includes workers, the unemployed, and others not in the labor force and incorporates Medicare and Medicaid, continue the labor movement's long-held goal of a social insurance national health care program while recognizing that reform may come about in stages.

Accordingly, we would support measures that would move the Nation toward our goals. Establish the national cost containment program that includes a cap on health expenditures, a capitol budget that manages the now uncontrolled duplication of technology, which you have heard about here today, and improves the allocation of resources and a Federal authority that negotiates uniform reimbursement rates with hospitals, doctors, and other providers to be used by all payers.

Create a national commission of consumers, labor, management, Government, and providers to administer the program. Guarantee a core package of health care benefits, supplemental benefits above the core package can be provided on a voluntary basis or through collective bargaining.

Contain progressive and equitable financing that requires all employers to contribute toward the health care coverage. Overhaul the existing administrative structure by establishing requirements for administrative intermediaries that would standardize claim forms, restrict the number of entities participating in the system, improve delivery of care, and assure that no individual would be denied coverage regardless of age, income, employment status, or prior health care history.

Reduce employment-based retirement health costs by dropping Medicare eligibility to age 60, putting the program in line with the average retirement age. Improve—well, Chairman Stark's announcement for this hearing mentions that a new Connecticut program includes establishment of standards of behavior for small group carriers, including requirements that all applicants be covered and rules for determining rates, creation of small employer health reinsurance pools.

Connecticut has already moved to do what it can for the 272,000 medically uninsured in our State, focuses on the people, especially children and pregnant women, the disabled, the elderly and people working for uninsured small businesses.

Twenty-five percent of the uninsured are children. According to the General Assembly's Health Care Access Commission, these people are not poor enough for Medicaid and not old enough for Medicare. Connecticut AFL–CIO retirees would prefer we attain national health care this year. At the very least, the reforms I have outlined should be enacted as a bridge toward our ultimate objective, national health care for all.

Thank you. [Applause.]

[The prepared statement follows:]

Statement by Renato E. Ricciuti
Coordinator of Retired Members of the
Committee on Political Education (Connecticut State AFL-CIO)
Before the
Subcommittee on Health
of the
Committee on Ways and Means Regarding Access to Health Care

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"We continue to support these principles today and believe that now is the time to renew the fight for national health care reform legislation consistent with our traditional support of a social insurance system. The labor movement is united in its determination to achieve universal access, significant cost containment, quality care and progressive financing.

"The current crisis -- the soaring cost of hospital care, physician services and prescription drugs; 37 million uninsured Americans; mounting threats to the quality of health care and continued strife at the bargaining table -- demands immediate action. The refusal of some employers to provide coverage has added to the cost of care for those who are insured, while millions of other Americans covered by health plans in the federal, public and private sectors have suffered the financial burden of increased cost-shifting and reductions in benefits.

"The urgency of the health care crisis for consumers and purchasers of care and for those who have fallen through the cracks in the current system requires us to seek relief now, without compromising our principles, and to support measures that can be enacted. Such proposals would move the nation to universal access by requiring all employers, including the federal government, to contribute fairly to the cost of care. Such measures also would introduce effective health care cost containment, improve the quality of care, streamline the complex and expensive structure of our current insurance system and advance the principle of progressive financing.

... "To succeed in this effort, the Federation will form coalitions with consumer groups, employers, community-based organizations and providers to call on Congress for expeditious enactment of federal legislation that will:

* "Guarantee all Americans the right to health care by establishing a national social insurance program that includes workers, the unemployed and others not in the labor force and incorporates Medicare and Medicaid.

* "Continue the labor movement's long-held goal of a social insurance national health care program, while recognizing that reform may come about in stages. Accordingly, we will support measures that would move the nation toward our goals.

* "Establish a national cost containment program that includes a cap on health expenditures, a capital budget that manages the now-uncontrolled duplication of technology and improves the allocation of resources, and a federal authority that negotiates uniform reimbursement rates (with hospitals, doctors and other providers) to be used by all payers.

* "Create a national commission of consumers, labor, management, government and providers to administer the program.

* "Guarantee a core package of health care benefits. Supplemental benefits above the core package can be provided on a voluntary basis or through collective bargaining.

* "Contain progressive and equitable financing that requires all employers to contribute toward health care coverage.

* "Overhaul the existing administrative structure by establishing requirements for administrative intermediaries that would standardize claims forms; restrict the number of entities participating in the system; improve delivery of care; and assure that no individual will be denied coverage, regardless of age, income, employment status or prior health care history.

* "Reduce employment-based retirement health costs by dropping Medicare eligibility to age 60, putting the program in line with the average retirement age.

* "Improve quality through the widespread dissemination of information to physicians through practice guidelines, create a national system for technology assessment and build a national data base on the cost and quality of care.

* "Encourage physicians to avoid unnecessary tests and medical procedures, while developing a better system for handling malpractice disputes.

* "Devise a strategy to provide all Americans access to long-term care and to make home care available to the chronically ill."

Chairman Stark's announcement for this hearing mentions that this new Connecticut program includes "establishment of standards of behavior for small group carriers, including requirements that all applicants be covered and ruleds for determining rates; creation of a small employer health reinsurance pool; provision of a special health care plan for previously uninsured groups; and expanded public programs for low-income residents.

Connecticut has already moved to do what it can for the 272,000 medically uninsured in our state. Focus is on the people, especially children and pregnant women, and people working for uninsured small businesses. Twenty-five percent of the uninsured are children. According to the General Assembly's Health Care Access Commission, the people are "not poor enough for Medicaid, not old enough for Medicare."

Connecticut AFL-CIO retirees would prefer we attain national health care this year. At the very least, the reforms I have outlined should be enacted as a bridge towards our ultimate objective, national health care for all.

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Chairman STARK. I have always said, Mr. Ricciuti, great minds run in the same direction, and now that I have shown my prejudice, Jerome Brown.

## STATEMENT OF JEROME BROWN, PRESIDENT, DISTRICT 1199, NEW ENGLAND HEALTH CARE EMPLOYEES

Mr. BROWN. Mr. Chairman, you showed it earlier.

Thank you very much for the opportunity to be here. I am president of the Health Care Workers Union in this State and in Rhode Island, and our members work every day taking care of people and obviously they are also recipients themselves of health insurance and health care, and their families.

Many of our members are low-paid nursing home workers, and people who work in community programs for the developmentally disabled, mentally ill. Health care insurance is an extremely important item for these workers.

I am the vice president of Service Employees International Union. I bring you greetings from Local 250 and from Local 79 and from different places around the country.

We have taken on the question of health care insurance as the most important issue facing our members and facing the country at large.

Indeed, the problems plaguing our Nation's health care system have been well documented. We have heard about the 37 million Americans uninsured. It has got to be higher than that today. That figure has been around for a number of years, and there is a depression on right now, and, so, that is horrible.

In Connecticut, it is really very, very difficult. This is a very rich State, and we are in a recession, but it is a rich State. New Haven has the highest infant mortality rate in the country. Three of our core cities, Hartford, Bridgeport, New Haven, have rates of infant mortality that are off the charts, that make us look like a Third World country.

We have increased health care spending by huge amounts, per capita increase from $1,148 in 1980 to $2,700 in 1990, well over 135 percent, double the inflation rate, and we still have serious problems with the quality of care as witnessed by the infant mortality. The increased cost has given us increased problems with access to care, which then goes to quality and everything else.

These are awful statistics, and we have to do something about them.

Now, the chairman referred earlier to the employment-based system. We are proud in organized labor to have negotiated health care benefits for workers. We established a system of almost, almost universal coverage if you were employed. That system is being eroded. It has been eroded. I mean it is gone.

The stable jobs in manufacturing that were the backbone of this country are changing. Service industries do not provide the same amount of insurance and many, many employers do not provide any health benefits at all to full-time workers.

Employment-based insurance cannot make it, will not be the solution. Although it has to be part of the solution. Employers should contribute to health coverage for their employees.

By the way, in answer to Congressman Levin, the first thing they should have done with that guy who had the person for 15 weeks and then took them off for the 16th week, somebody should have thrown him in jail, the second thing is the worker should go on strike.

But, by the way, strikes cannot do it. That is the problem. We cannot carry the burden. We have had strike after strike on health care benefits, and using many of the laws that do not protect us any more as well as maybe they used to, we get decertified. They bring in permanent replacements, scabs, for hire, and decertify the union when we are fighting for the health care system for the rest of this country, to set decent standards.

We cannot carry the burden. We have had strikes in this State, in nursing homes, in the university over health benefits. You cannot necessarily blame the individual employer. They are under a huge pressure, whether it is competitive or just the rising cost is driving them crazy.

You know, I wish it were as simple as to say they are SOBs, but it is not necessarily that. The economics of it mean that the employment-based system cannot necessarily take it. We fight like the devil for it. We have strikes for it. We are not letting anybody get away easy on this, but the fact of the matter is that it keeps running away from us and keeps running away from workers generally.

There has got to be another kind of solution, and, by the way, it has got to address cost, not just access. This country, as rich as it is, cannot afford a health care system with costs rising 12 percent a year when the rest of the country is at 6 percent inflation. By the year 2010, 50 percent of the budget will go to health care. It is impossible. The country cannot afford it, whether it is paid for by taxes or shared insurance or employer insurance or whatever, it cannot afford it. It has got to control costs before you get to access or at the same time that you are getting to access. The employers have to pay, all of them have to pay.

We have to wring out of the health care system the excess costs. I do not know that there is a way to design a system that makes all of the players happy.

The panel that was up here just before us, if we have our way, they are not going to be happy, because they are taking 20 to 25 percent of the health care dollar and putting it in insurance overhead and profits. It cannot do that. There is not enough dollars to allow that. It has got to go to health care.

I am the chairperson of a 5,000–6,000 member health fund. Some 6,000 people are involved in the health care fund and they get their benefits through it. That fund is an anachronism, it is a dinosaur. We should go out of existence at the same time that CIGNA does. Not before, but the same time that they do, because it is a waste of dollars to spend it in that type of administration, and we do not have them.

So we are very, very pleased to be here. We represent low-paid workers, some high-paid workers, all of our members are under extreme pressure from their employers on the question of health care insurance. Many of them do not have it for their families. We want to have a real families policy in the U.S. Congress to make sure

that mothers and fathers that work for a living can have decent health care for their kids without begging for it or going to the city hospitals in Oakland and waiting on long lines. I have been there, and I have seen them visiting, our members there. It is no way for this country to give health insurance.

We thank you for the opportunity. We want systemic reform. You cannot just fix this in little pieces. It has got to be systemic reform.

Thank you very much.

[The prepared statement follows:]

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Jerry Brown, President
Healthcare Reform Testimony
Hartford, Connecticut
February 25, 1991

My name is Jerry Brown and I am the President of District 1199 of the New England Health Care Employees Union and a Vice President of the Service Employees International Union, AFL-CIO. New England Health Care Employees Union District 1199 represents sixteen thousand (16,000) health care professionals, para professionals and service employees in Connecticut's hospital, nursing home and group home industries, as well as workers employed in State Department's of mental health and mental retardation. The Health Care Division of the Service Employees International Union represents 425,000 health care employees throughout the United States, Puerto Rico and Canada, making SEIU the largest Union of health care employees in North America.

I want to thank Congresswoman Kennelly and the other members of the Subcommittee on Health of the Committee on Ways and Means for holding these hearings today to address the issue of healthcare reform. I am pleased that the Subcommittee is providing this opportunity to expand the debate on the healthcare crisis that is gripping our nation.

The problems plaguing our nation's healthcare system have been well documented. We've all heard about the 37 million Americans without access to health insurance in this country. We are also well aware that the U.S. has the most expensive healthcare system in the world, but still lags behind almost every other industrialized country in life expectancy and infant mortality.

But I'd like to dramatize the problem with a few examples that are a little closer to home.

The situation here in Connecticut pinpoints some of the flaws underlying the nation's health delivery system.

Last fall, Citizen Action released a study detailing the rise in each state's healthcare spending over the past decade. Per capita health spending in Connecticut jumped from $1,148 in 1980 to $2,699 in 1990 -- an increase of over 135 percent. That's more than twice the rate of general inflation.

But has the rise in healthcare spending translated into a higher quality of care or a healthier population? The answer is no.

Connecticut's per capita health spending ranks sixth highest in the country. Yet three of our cities, New Haven, Bridgeport and Hartford, are among the top 20 cities in the U.S. with the highest rates of infant mortality. And New Haven has the shameful distinction of heading the list with an infant mortality rate of 20.2 infant deaths per 1,000 live births.

We sound more like a third world country than a state with the nation's highest per capita income.

Given these kinds of disturbing statistics, it is no wonder that healthcare reform is gaining momentum as one of the driving issues of the 1990s.

And organized labor is leading the charge.

In the last few years, health care has taken its place alongside wages, hours and job security as a no-surrender strike issue. More and more workers are taking to the picket lines to defend their healthcare benefits. Health was a key strike issue for 78 percent of workers on major strikes in 1989, up from 18 percent in 1986.

In Connecticut our Union has experienced two unfortunate strikes in the last twelve months involving health care insurance issues.

At Kimberly Hall Nursing Home in Windsor, Connecticut, one hundred and thirty employees went on strike one year ago. The Employees of Kimberly Hall (owned by the Pennsylvania based Genesis Corporation), earned between seven and eight dollars per hour and paid fifty-five dollars per week for family health insurance coverage. The strike was declared a lockout by the State of Connecticut because the Employer refused to allow the workers to return to their jobs. This dispute continues today and is currently before the National Labor Relations Board.

One hundred twenty members at the University of Bridgeport struck for one month this past fall. The Employer insisted on an insurance co-payment that cut take home pay for the members ten to thirteen percent. The strike involved an additional four hundred employees represented by other Unions. One Union is still on strike.

Most of our members have thus far escaped tragic strikes over health benefits, however, the threat of many such conflicts is near at hand.

For example, the Union is party to a Taft-Hartley Trust Fund that provides health insurance coverage to five thousand of our Union members. Health care prices have risen so dramatically in the past few years that the Benefit Fund cost is now eighteen percent of gross payroll although present contribution rates from employers are twelve to fourteen percent of gross payroll. The fund's surplus has dropped to a six month level as compared to a two year level eighteen months ago. The contracts covering these employees expire next year.

Because none of the employers have offered to shoulder the full burden of health care costs the rapid increases presents these five thousand members covered by the 1199 fund with two choices; either strike to defend their benefits and living standards or suffer a drastic reduction of benefits and standard of living.

What does a decrease in standard of living mean for our members at Mt. Sinai Hospital in Hartford? Consider Annette Gordon, a transport orderly who earns $8.72 an hour after five years of employment. Annette's take home pay is less than three hundred dollars per week. On this pay she supports herself and her child while attending nursing school. Does anyone at this hearing really believe that Ms. Gordon can afford a co-payment on her insurance?

Out of the heightened conflict between labor and management on this issue has come a point of consensus. Both sides agree that the problems have become too big to solve employer by employer or union by union.

Nothing short of a comprehensive overhaul of the nation's healthcare system will solve the triple problems of access, cost and quality. The United States needs a national healthcare system based on social insurance to guarantee every American access to high quality, affordable health care.

This is a goal that organized labor has strived to achieve for many decades. As we watch the collapse of employment-based health coverage, the issue has taken on greater urgency.

Labor began its full-scale reform effort last year when the AFL-CIO Executive Council approved a resolution calling on all unions to mount a campaign for national health care.

The AFL-CIO's Health Care Committee, headed by SEIU's President Sweeney, assumed responsibility for developing a recommendation for comprehensive reform at the national level -- as well as a plan for building a coalition, educating the public and our members and, finally, persuading the U.S. Congress to act.

Throughout the fall, the AFL-CIO held eight hearings around the country to dramatize the importance of the healthcare issue.

And last week at the annual midwinter meeting, the AFL-CIO Executive Council adopted a statement endorsing a broad proposal for national healthcare reform. The plan calls for comprehensive reform of the nation's healthcare system, addressing matters of cost, access and quality.

The position specifies that a national cost containment program, which would be directed by a new national commission, be established. The commission would issue uniform payment rates for all purchasers of care, set a national cap on total health expenditures, and put in place a separate, national budget for construction of health facilities and purchase of expensive technology.

The plan would guarantee a core package of health benefits for all Americans, require all employers to contribute toward the health coverage of their work force, and put in place a system of progressive and equitable financing.

Organized labor has traditionally supported a national social insurance program as the best way to go and still does. But the AFL-CIO is not insisting that healthcare reform be addressed as a social insurance plan immediately. We are bringing our reform efforts into the political process, working with other coalitions to gain sufficient support to make enactment possible.

The urgency of the healthcare crisis demands that we mobilize to gain action as soon as possible.

To this end, the labor movement is enlisting the help of its rank and file members through a nationwide grassroots campaign to promote healthcare reform.

The AFL-CIO is forming coalitions with consumer groups, employers, community-based organizations and providers to urge Congress to enact national healthcare reform legislation.

Working within these coalitions, we aim to make healthcare reform the number one domestic policy issue in the 1992 presidential elections.

I hope that we can count on your support to reform our healthcare system into one that provides for the needs of all Americans.

Thank you.

Statement by the AFL-CIO Executive Council

on

National Health Care Refor-

February 19, 1991
Bal Harbour, Florida

Since the 1920s, unions have advocated national reform of the health care delivery system to guarantee all Americans, from children to seniors, the right to health care.

We have supported passage of federal legislation that moves toward the goal of a national social insurance program. We have supported a requirement that all employers contribute their fair share to the cost of care. We have supported that development of a national cost containment system to prevent shifting of costs from one payer to another.

We continue to support these principles today and believe that now is the time to renew the fight for national health care reform legislation consistent with our traditional support of a social insurance system. The labor movement is united in its determination to achieve universal access, significant cost containment, quality care and progressive financing.

The current crisis--the soaring cost of hospital care, physician services and prescription drugs; 37 million uninsured Americans' mounting threats to the quality of health care and continued strife at the bargaining table--demands immediate action. The refusal of some employers to provide coverage has added to the cost of care for those who are insured, while millions of other Americans covered by health plans in the federal, public and private sectors have suffered the financial burden of increased cost-shifting and reductions in benefits.

The urgency of the health care crisis for the consumers and purchasers of care and for those who have fallen through the cracks in the current system requires us to seek relief now, without compromising our principles, and to support measures that can be enacted. Such proposals would move the nation to universal access by requiring all employers, including the federal government to contribute fairly to the cost of care. Such measures also would introduce effective health care cost containment, improve the quality of care, streamline the complex and expensive structure of our current insurance system and advance the principle of progressive financing.

In this regard, the federal government must be a model employer and establish the standard by ensuring that its plan operates within these principles. There is also a need to address the problem of retiree health costs in the coal industry and other sectors.

We call upon all affiliates to join the Federation's nationwide grassroots campaign by mobilizing their members in an all-out lobbying effort to win national reform.

To succeed in this effort, the Federation will form coalitions with consumer groups, employers, community-based organizations and providers to call on Congress for expeditious enactment of federal legislation that will:

**National Health Care Reform**

* Guarantee all Americans the right to health care by establishing a national social insurance program that includes workers, the unemployed and others not in the labor force and incorporates Medicare and Medicaid.

* Continue the labor movement's long-held goal of a social insurance national health care program, while recognizing that reform may come about in stages. Accordingly, we will support measures that would move the nation toward our goals.

* Establish a national cost containment program that includes a cap on health expenditures, a capital budget that manages the now-uncontrolled duplication of technology and improves the allocation of resources, and a federal authority that negotiates uniform reimbursement rates (with hospitals, doctors and other providers) to be used by all payers.

* Create a national commission of consumers, labor management, government and providers to administer the program.

* Guarantee a core package of health care benefits. Supplemental benefits above the core package can be provided on a voluntary basis or through collective bargaining.

* Contain progressive and equitable financing that requires all employers to contribute toward health care coverage.

* Overhaul the existing administrative structure by establishing requirements for administrative intermediaries that would standardize claims forms, restrict the number of entitles participating in the system, improve delivery of care; and assure that no individual will be denied coverage, regardless of age, income, employment status or prior health care history.

* Reduce employment-based retiree health costs by dropping Medicare eligibility to age 60, putting the program in line with the average retirement age.

* Improve quality through the widespread dissemination of information to physicians through practice guidelines, create a national system for technology assessment and build a national data base on the cost and quality of care.

* Encourage physicians to avoid unnecessary tests and medical procedures, while developing a better system for handling malpractice disputes.

* Devise a strategy to provide all Americans access to long-term care and to make home care available to the chronically ill.

Chairman STARK. Thank you. [Applause.]
Mr. Rome.

## STATEMENT OF ETHAN S. ROME, LEGISLATIVE AND POLITICAL DIRECTOR, CONNECTICUT CITIZENS ACTION GROUP

Mr. ROME. Thank you.

Mr. Chairman, members of the committee, good morning. I am Ethan Rome. I am the legislative and political director for the 100,000-member Connecticut Citizens Action Group.

I represent the CCAG Health Care For All Coalition, which is a network of more than 50 community, civil rights, provider, disabilities, senior citizen, labor, and other organizations, including the organizations to my right.

I was a member of the Blue Ribbon Commission on State health insurance and am now a member of the State's Health Care Access Commission.

It is an honor to come before your committee, and I thank you for holding this hearing in Connecticut.

There has been several descriptions of the health care crisis and our health care system this morning, and there is only one of those descriptions which resonates with the experience of most Americans. That is that our system is a mess. The health care crisis is hurting everyone.

When you take a look around, workers are paying more and getting less coverage. Businesses cannot keep up with the spiraling costs. The uninsured are forced to go without needed care. The elderly cannot afford the services they need. People with disabilities and health care needs are regularly denied coverage, and urban and rural areas lack the medical services they need.

It is bad now and getting worse every day. What do we do about it? There is only one comprehensive and workable solution to this problem. We need a universal and unitary health care plan that controls skyrocketing costs and covers every individual under a single public insurance policy.

Specifically, a universal health care system should be based on the following principles:

First, coverage should be universal and equal.

Second, benefits must be comprehensive.

Third, services should be accessible.

Fourth, costs should be effectively controlled.

Fifth, high-quality care should be uniform.

Last, the program should be publicly administered and funded with a fair financing mechanism.

Now, if we had—if our health care system today was based on any one of those principles, we would be much further along than we are.

While we have struggled to reform our failing system, our neighbors have enjoyed one of the finest health care systems in the world. Canada's national health care program is an extraordinary example. Every Canadian has comprehensive health coverage and the freedom to select the doctors and providers of their choice.

The quality of their care is excellent, and they spend 25 percent less per capita on their health care than we do. The Canadians achieved these results because of the simplicity of their system.

First, they eliminated administrative waste by having one plan that covers everyone and pays for all services.

Second, they control costs by negotiating hospital budget and physician fees. The result, universal access to a single standard of care at an affordable price. Again, all things we do not have.

There is another side to this story, of course, and it is told by those who have a vested interest in keeping our system the way it is and opposing a real solution. Doctors, the insurance industry, and others have been perpetuating myths about the Canadian system.

Let us talk about a few of those. One of the most popular myths is that universal health care is too expensive. Well, in Connecticut, we are spending $8 billion a year right now in total health care expenditures. That is more than our entire State budget. Meanwhile, the 300,000 people are uninsured and everybody else cannot afford their care.

According to the consultants to the Blue Ribbon Commission on State health insurance, if we had a universal program in Connecticut, we could cover everyone in this State and spend $393 million less per year. It seems to me this is a direction we ought to take.

Another favorite myth, of course, is that Government is inefficient and cannot effectively run this kind of program. You all know those numbers. It costs insurance companies roughly 12 percent overhead costs for their insurance policies. For Medicare, Medicaid, and Canada's provincial plans, the number is 3 percent.

The biggest myth, of course, is that the Canadians ration care while the rest of us do not. Well, let us be clear about that. We ration care in the United States, and we do so based on ability to pay. It is unfair. It is discriminatory, and it is disgraceful.

Last, we are told that the American people do not support universal health care. The opposite is the case. In poll after poll, the vast majority of Americans say that our system needs fundamental change, but Americans are even more specific. Around 60 to 70 percent of Americans polled consistently say that they favor a Canadian plan.

The Canadian system provides a detailed framework and a stunning example. Most of all, it offers a system, a structure, and a set of mechanisms that work. We must develop a program of our own, however.

Through the Blue Ribbon Commission on State health insurance, Connecticut enacted a landmark package of reforms that expand insurance coverage and increase access to care, and you have certainly heard about those this morning.

We, CCAG, played an instrumental role in that effort, first in establishing the Blue Ribbon Commission in 1989, and then in helping the commission and legislature develop the programs that passed last year.

Short-term programs that meet the immediate health care needs of the uninsured are certainly critical, but there are serious limitations to these kinds of programs. In the long-term, tinkering with

our system will not work and piecemeal programs will simply not solve this problem.

In the short-term, it is not clear how much we can accomplish, thanks to budget restraints, and the amount of time it takes to implement even the most simple of programs. Universal health care is the only solution, so we might as well get started on it now. There is a basic question for us to ask ourselves, which is how long do we have to wait, how long do we have to wait to join every other industrialized nation in the world, except South Africa, to have a universal health care system.

We need to ask that question today and take action on it today. We need a national health care program to solve this problem. Congressman Marty Russo, a member of your committee, has proposed a bill which establishes a comprehensive, universal, and unitary national health care program. We strongly urge you to support the Russo proposal.

And, last, new initiatives will certainly have to come from the States. The Health Care For All Coalition supports a universal and unitary system in our State, but we cannot do that without Federal waivers. I strongly urge you to support Federal waivers for Connecticut and other States.

Thanks very much. [Applause.]

[The prepared statement follows:]

**Statement of Ethan S. Rome, Legislative and Political Director, Connecticut Citizen Action Group.**

**Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Field Hearing on Access to Health Care.**

**February 25, 1991**

Mr. Chairman, Representatives Kennelly and Johnson, good morning. I am Ethan Rome, the Legislative and Political Director for the 100,000 member Connecticut Citizen Action Group (CCAG). I represent the CCAG Health Care For All Coalition, a network of more than 50 community, civil rights, provider, disability, senior citizen, labor and other groups. I was a member of the Blue Ribbon Commission on State Health Insurance last year, and now serve on the state's Health Care Access Commission.

It is an honor to come before your committee to discuss one of the most pressing issues we face--access to health care. Thank you for holding this hearing here in Connecticut.

**We can no longer ignore the plain truth: our state and nation's health care system is a mess.** More than 300,000 Connecticut residents are uninsured and cannot get needed care, while hospital beds lie empty, and millions of dollars are squandered on bureaucracy, waste and profits. Skyrocketing costs overwhelm businesses and bust the budgets of families trying to make ends meet.

**The health care crisis is hurting all of us.** Workers are paying more and getting less coverage. Businesses can't keep up with spiraling costs. The uninsured are forced to go without needed care. The elderly cannot afford the services they need. People with disabilities and health care needs are regularly denied coverage. And urban and rural areas lack critical medical services. It's bad now, and getting worse every day.

**There is only one comprehensive and workable solution to this problem: we need a universal and unitary health care plan that controls skyrocketing costs and covers every individual under a single, public insurance policy.**

**Specifically, the plan should be based on the following principles:** first, coverage should be universal and equal; second, benefits should be comprehensive; third, services should be accessible; fourth, costs should be effectively controlled; fifth, high quality care should be uniform; and lastly, the program should be publicly administered and funded with a fair financing mechanism.

While we have struggled to reform our failing system, our neighbors have enjoyed one of the finest health care systems in the world. Canada's national health care program is an extraordinary example. **Every Canadian has comprehensive health coverage and the freedom to select doctors and hospitals of their choice. The quality of their care is top notch, and they spend 25 percent less per capita on their health care than we do.**

**The Canadians achieve these results because of the simplicity of their system.** First, they eliminate administrative waste by having one plan that covers everyone and pays for services. Second, they control costs by negotiating hospital budgets and physician fees. The result is universal access to a single standard of care at an affordable price.

There's another side to this story, of course, and it's told by those who have a vested interest in opposing a real solution to the health care crisis. **Doctors, the insurance industry and others have been perpetuating myths about the Canadian system, and that just what they are--myths.** Consider the following examples.

One of the most popular myths is that universal health care is too expensive. Well, in Connecticut we already spend $8 billion dollars a year in total health care expenditures, more than our entire state budget. According to the consultant to the Blue Ribbon Commission on State Health Insurance, **if we had a universal program**

**in Connecticut, we could cover everyone in Connecticut and spend $393 million less per year than we do now.**

Another favorite is that government is inefficient and cannot effectively run this kind of program. The facts show otherwise: **insurance company overhead costs are 12% of total premiums, while Canadian provincial plans and U.S. Medicaid and Medicare run an overhead of less than 3%.**

The biggest myth is that the Canadians ration care. **Let's be clear--we ration care in the United States, and we do it based on ability to pay.** It's unfair, it's discriminatory and it's disgraceful. Increasingly, we also ration care through HMO's, utilization review managed care and other schemes. The question is, who makes the decisions about rationing? Are they made by corporate executives behind closed doors, or are they publicly debated and democratically decided?

Lastly, we are told that the American people do not support universal health care. The opposite is the case. In poll after poll, the vast majority of Americans say that our system needs fundamental change. **And between 60% - 70% of all Americans consistently say they would favor a system like the one in Canada.**

The Canadian system provides a detailed framework and a stunning example. Most of all, it offers a system, a structure, a set of mechanisms that work. It's not a blueprint. We must develop a program of our own.

Through the Blue Ribbon Commission on State Health Insurance, Connecticut enacted a landmark package of reforms that expand insurance coverage and increase access to care for the most vulnerable of the uninsured. **Fully implemented, these initiatives will insure roughly 60,000 of state's uninsured population.** The CCAC Health Care For All Coalition played an instrumental role in that effort--first in establishing the Commission in 1989, and then in helping to develop the programs and lobby the bill last year. I am proud of that work.

**Short-term programs that meet the immediate health care needs of the uninsured are critical.** That's why our number one priority this year at the Legislature is to help design the program for pregnant women and children contained in last years' bill, and to get those programs funded.

**But there are serious limitations to these kinds of programs.** In the long-term, tinkering with our system will not work, and piecemeal programs will not solve the problem. In the short-term, it's not clear how much we can accomplish, thanks to budget restraints and and the amount of time it takes to implement even the most simple of programs. **If we are going to enact piecemeal programs, we must at the same time get started on developing a comprehensive program.** If a short-term initiative does not move us closer to a universal program that controls costs, it is a step backwards. **Universal health care is the only solution, so we might as well get started on it now.**

Ultimately, we need a national program to solve this problem. Congressman Marty Russo, a member of your committee, has proposed a bill which establishes a comprehensive, universal and unitary national health care program. **We strongly urge you to support the Russo proposal.**

New initiatives will also have to come from the states. **The Health Care For All Coalition supports establishing a universal and unitary plan in Connecticut that solves immediate problems and builds toward national action.** But we cannot move forward in Connecticut without federal waivers that would allow us to fold Medicaid, Medicare and other federal health care dollars into a state plan. **We strongly urge you to support federal waivers for Connecticut and other states.**

I would be happy to answer any questions you may have. Thank you.

Mr. DONNELLY. Thank you.

Janet Spegele, vice president of Connecticut Business and Industry Association.

## STATEMENT OF JANET C. SPEGELE, VICE PRESIDENT, CONNECTICUT BUSINESS AND INDUSTRY ASSOCIATION

Ms. SPEGELE. Thank you, Representative Donnelly, Representatives Johnson and Kennelly, and other members of the Ways and Means Subcommittee on Health. Thank you very much for inviting me to speak today at this special field hearing on health care access.

I am sorry. You are probably aware that this is not a totally homogenous panel, unlike some of the others, and I do not know if all of my people are here to give me applause when I am finished, but thank you for having me included on this panel today.

Access to health care is indeed a problem, and for Connecticut businesses as for other consumers of health care, the major impediment to access is cost. Every year, CBIA does conduct a survey of its membership to identify areas of special concern to employers. In this year's survey, as in every previous survey, the overwhelming majority of employers report that they do provide health insurance coverage to employees, and in this year's survey, that showed to be 97 percent of our membership responding to the survey do now provide health insurance to their employees.

But the cost of this coverage has increased at startling rates over the last year. When I was looking at the survey, I was surprised to find that the statistics given in Chairman Stark's press release of 20 to 40 percent were indeed very close to our survey results with a fifth of our members responding that their health insurance rates rose as high as 40 percent over the last year.

With costs of this magnitude, it is no surprise to find from this membership survey that employee health insurance costs are the number one cost concern for Connecticut businesses. They are out-pacing taxes. They are out-pacing workers compensation and every other cost of doing business in this State.

Faced with these escalating costs, employers have been compelled to find ways to slow the increases or jeopardize their ability to compete nationally and internationally. And employers are responding a number of ways. They are instituting managed care elements which you have heard something about today in an earlier panel. They are changing health care designs to introduce things like flexible benefit plans. And they are asking employees to share the cost of coverage.

Again, in our survey, over 50 percent of employers reported that they had initiated or that they have increased employee contributions to health insurance coverage over the last year.

On the one hand, employees who have a stake in paying for their health care are hopefully going to be more efficient in using that care. In the long run, more efficient utilization hopefully will stabilize the cost of medical care or help to stabilize the cost of medical care and medical insurance.

On the other hand, employees who are asked to share in the costs of medical insurance may choose to do without insurance

rather than contribute. I can only wonder at times how many of the numbers of the medically uninsured who are employed or dependents of employed have been offered insurance on a cost-sharing basis through an employee plan, through an employer plan, but have chosen not to contribute to the cost because they have not been able to afford to do so.

Just as individuals cannot afford the cost of coverage, certain employers simply cannot afford the costs either. And what we have with this cost problem is a real deterring of the expansion of employee health insurance coverage in the private sector as a result of the cost.

The problem is one that we are all aware of and well known. Still elusive is the solution to the problem. We believe, however, that there are constructive steps that can be taken, and that the Federal and State government working with the private sector can move toward the solution.

I am not going to go into what we are very hopeful about, which is the recommendations that came out of the Blue Ribbon Commission on State health insurance that did recommend a—that does represent a multifaceted approach to expanding not only access to health insurance but access to health care in the State. But some of those approaches are not insurance driven; they have to do with better support or more extensive support of community health centers which we feel are very major delivery systems that really gives care at the point that it is most needed.

Our greatest hope is focused in the health insurance reform aspects because as CBIA does represent a large number of employers but most of them are small employers and for those small employers that have been faced with very erratic measures in the health insurance market, we are hoping that those health-insurance reforms will make a difference.

There are other constructive steps, and we feel that the Government has a role to play, not only in trying to come up with tax incentives to encourage small businesses to provide health insurance benefits, but also to fully fund the program, the entitlement programs that have been instituted at the Federal and State level, both Medicare and Medicaid.

I know there has been some debate about whether there is adequate funding on the Medicare level. We could probe that further in questions. We do have some experience in having tracked some of the hospital regulation process here in the State of Connecticut where we tried to stop cost shifting and it really did exert an incredible pressure on the hospitals in this State. And right now, we have a hospital regulation system that allows the cost shifting because of the hospitals' belief and to some extent we are persuaded that the reimbursement levels have not necessarily been adequate.

In addition to the funding levels, we are really talking about eligibility with Medicaid as well and the expansion of the eligibility to draw in more people. It has been estimated that if Medicaid were expanded to include individuals at 200 percent of the poverty level, the expansion would reduce the number of uninsured individuals by two-thirds. So that alone could make a major difference in terms of affecting the rate of uninsureds.

Finally, among the steps that can be taken are ones that have to do with product design and development. We are very much advocates of a managed care approach. We feel it can work. It has worked within the private sector, and it has got to be given a chance to really work, and I would like to add my comments to those of other speakers on the previous panel who have been concerned about the regulations that might cripple or be disincentives to the real expansion of managed care alternatives. I would add to the product development approach the approach that we do not have in this State, but we would certainly, I think, benefit from it, which is the ability to be providing lower cost health insurance products by eliminating or reducing some of those very costly mandates that are required by State—by our State here.

My bell has rung. So I will stop and will accept your questions. Thank you.

[The prepared statement follows:]

TESTIMONY OF JANET C. SPEGELE
VICE PRESIDENT
CONNECTICUT BUSINESS AND INDUSTRY ASSOCIATION
370 ASYLUM STREET
HARTFORD, CT 06103

Chairman Stark, Reps. Kennelly and Johnson, and members of the Ways and Means Subcommittee on Health, thank you for inviting me to speak today at this special field hearing on Access to Health Insurance.

My name is Janet Spegele. I am a vice president for the Connecticut Business and Industry Association (CBIA). CBIA represents approximately 7,000 firms, which employ over 700,000 women and men in Connecticut. Our membership includes firms of all sizes and types; however, the vast majority are small businesses with fewer than 100 employees.

Access to health insurance is indeed a problem. And for Connecticut businesses, as for other consumers of health insurance, the major impediment to access is cost. Every year, CBIA conducts a survey of its membership to identify areas of special concern to employers. In this year's survey - as in our previous surveys - the overwhelming majority of employers report that they provide health insurance coverage for employees (97 percent). But the cost of this coverage has increased at startling rates over last year:

- 70 percent of employers report that the cost of health insurance rose more than 20 percent; and

- 20 percent of employers report increases of more than 40 percent.

But even more significant than the rate of increase, is the proportion of dollars spent on employee health-insurance coverage. One major Connecticut manufacturer has done an analysis of health-insurance spending in relation to employee wages over the last 10 years. He found that whereas 10 years ago employee health-insurance costs represented 18 percent of the average hourly wage paid to the company's employees, today his company's health insurance costs represent 30 percent of the average hourly wage.

This 30 percent add-on to wages must be factored into any decision concerning whether or not to expand the workforce and whether or not to reduce the workforce.

With costs of this magnitude, it's no surprise to find from CBIA's membership survey that employee health-insurance costs are the number-one cost concern for Connecticut businesses, outpacing even business taxes. Faced with these escalating costs, employers have been compelled to find ways to slow the increases or jeopardize their ability to compete nationally and internationally.

And employers are responding in a number of ways: They're instituting managed care elements into their insurance plans for more efficient utilization of services; they're changing health-care plan designs, such as HMOs and flexible benefit plans; and they're asking employees to share the costs of coverage. (Over 50 percent of employers report having initiated or increased employees' contributions for health insurance coverage over the last year.)

On the one hand, employees who have a stake in paying for their health care are likely to be more efficient users of this care. And in the long run, more efficient utilization could help stabilize the costs of medical care and medical insurance. On the other hand, employees who are asked to share in the costs of their medical insurance may choose to do without insurance rather than contribute. I can't help but wonder how many among the numbers of the medically uninsured who are employed or dependents of employed have been offered insurance on a cost-sharing basis through an

employer but have chosen not to contribute to the costs.

Just as some individuals can't afford the costs, some employers simply can't afford to provide employee health insurance coverage. Thus, the high cost of insurance is deterring the expansion of employee health insurance coverage in the private sector.

But while the problem of access to health insurance is well known, still illusive is the solution to the problem. We believe, however, that there are constructive steps that can be taken by the federal and state governments and by the private sector that move toward a solution.

Insurance underwriting reforms

One significant approach is the health-insurance underwriting reforms for the small-business market enacted in 1990 by the Connecticut General Assembly.

Of the working uninsured, the largest proportion is employed by small businesses. Small businesses are the least likely to be able to afford health insurance for their employees. But they are also the most likely to be confronted with difficulties in obtaining coverage, with prohibitively high initial premiums and renewal rates, and with the risk of discontinuance of coverage.

Connecticut's new underwriting reforms are aimed at guaranteeing coverage for small employers and stabilizing prices. These reforms have been strongly supported by Connecticut's business community, and we are very hopeful that they will expand access to health insurance to more small businesses and thus to the many individuals working for these employers.

Government programs

Congress should offer tax incentives to encourage small businesses to provide health-insurance benefits for their employees.

At the same time, both federal and state governments must live up to their responsibilities and adequately fund the Medicare and Medicaid programs. The narrow eligibility criteria for federal and state health insurance programs has left a significant portion of individuals who are at or near the poverty level outside the Medicaid system. It has been estimated that if Medicaid were expanded to include individuals at 200 percent of the poverty level, the expansion would reduce the number of uninsured individuals by two-thirds.

In addition, the federal and state funding that is available is not keeping pace with rising health-care costs. Medicare and Medicaid reimbursements fall short of the full cost of medical care. To cover the shortfalls, hospitals and doctors are passing on the loss to private patients and therefore to employer-funded health insurance.

Thus, employers are not only paying the costs of medical care for their employees and employee dependents, but they are funding the deficits created by inadequate Medicare and Medicaid reimbursements.

Adequate funding means providing reimbursements to cover the costs of care for those currently eligible for these programs and expanding eligibility to cover those who are at or near the poverty level (e.g. at 200 percent of the poverty level). Adequate government funding would eliminate or significantly reduce the private-sector subsidy of government shortfalls and make private insurance more affordable for employers and employees.

Product Development

Many state laws enumerate an expensive list of specific procedures required to be covered by all group health insurance sold in the state. But requiring insurance policies to provide numerous coverages also serves to price health insurance right out of the market for many employers and employees. On the other hand, basic health-benefit packages can be provided at significant cost-savings.

State and federal governments must be open to the potential for expanding access to health insurance offered by flexible medical-benefit packages. A number of states (e.g., Virginia, Missouri, Washington, Florida) have already waived benefit mandates to allow insurers to develop and market basic-coverage, affordable products.

In addition, managed care programs, utilizing a network of selected health-care providers, have proven to result in significant cost savings without sacrificing quality of care. Yet, too often efforts to develop managed-care and other cost-containment programs have been impeded by government prohibitions and regulations.

Rather than impeding creative cost-containment approaches, government's role should be to assure that regulation and incentives are balanced to encourage affordable insurance plans and managed-care systems.

There is no single answer to the complex problem of how best to expand access to health insurance coverage. But taking steps to make coverage more affordable will go a long way to making it more available.

Thank you.

Chairman STARK. I want to thank the panel. I just interrupt here for a minute to apologize to this panel and to the remaining panel.

Through deregulation of the airlines, it will be impossible for us to make it back to Washington unless we leave in about the next 10 minutes and turn the gavel over to Mrs. Kennelly and Mrs. Johnson, who are going to stay here and finish it. I just wanted to apologize for having to move along. It is largely because the chairman was so long-winded that the rest of you did not get a chance to get interrogated, but I thank this panel, and I find it particularly refreshing to see Ms. Spegele, Mr. Rome, Mr. Brown, all who may represent somewhat different constituencies. I think we all recognize the problems we face, we are not going to solve them, till somehow we can get a coalition.

Somewhere in some room, we are going to have to get half of the people plus one to pick a program and go with it, even—unlike my friends in Florida last week, who could not get that one vote, it was 8 to 8. Until then we have got a political problem. I appreciate the work you are doing, in spite of the fact that I might do it differently. I am not writing the plan for Connecticut. I think it is creative when States are willing to work together and face this problem, and you are going to help us do it.

I am out of order here, but I just wanted to say before I have to run off and turn this over to our two Connecticut representatives.

Mrs. Kennelly. I am sorry. Mrs. Johnson, did you want to inquire at this point?

Mrs. JOHNSON. Actually, I am not going to inquire in hopes that we will be able to get on to the legislators before some of the members have to leave, but I do want to just make one small comment.

It is impressive the amount of consensus that is building in our society. All of your testimony has spoken to the Connecticut plan, which is a core benefits plan. The AFL-CIO recognition that it is the core benefits that we ought to guarantee and above that have an opportunity for collective bargaining to deal with a portion of the problem, and, so, and I personally feel very strongly about guaranteeing universal access to a core benefit plan, but I would ask your further consideration and later discussion with me about two things.

First of all, if we move toward that, the AFL-CIO testimony does recognize the need if we are going to work within practice guidelines, if we are going to avoid unnecessary tests and so on, to revisit the issue of malpractice reform, both process reform and the liability structure within which we practice medicine.

No other nation practices medicine under the legal constraints that we do. Not Canada, not England. You know, you cannot bring suits there with collateral fees. I mean it is just a radically different system, and we need to look at the relationship between practicing under guidelines and within a discipline that pushes out unnecessary testing and liability exposure, and, last, I am particularly interested in the AFL-CIO's interest in caps.

It is a very realistic matter to discuss, but we do, after all, have three cap systems in place, and they are not doing very well. We capped the VA systems, its bottom line costs, and we have really eroded access and quality. We capped the Medicaid reimbursements and we have dramatically eroded access and quality, and, so,

I think that if we are going to go that direction, we have the responsibility to build into the system some way to assure that the caps will be realistic, that the reimbursement rates will not fall prey to what every reimbursement rate structure has fallen prey to, and that is people's unwillingness to pay taxes.

So while all those polls show everybody wants it, the polls also show nobody is willing to pay for it. So I think in all fairness to ourselves, we need to look at how we are going to bind ourselves to put the money in, and I for one know we are going to have to put more money in, and I support putting more money in, but I think reliance on us to rationally reimburse is to hold out false hope for the future.

So with those comments to my concerns and my response to your testimony, let me pass the microphone to my colleague.

Mrs. KENNELLY. I just would ask Mr. Rome if he could share with us the basic differences between the Canadian plan and our system and, further, how you would pay for the system as described in your testimony.

Mr. ROME. We can certainly provide that.

Mrs. KENNELLY. And then I will have it inserted in the full record.

Mr. ROME. OK.

[The information follows:]

Ways and Means Committee Questions for Ethan Rome

What are the basic differences between the Canadian and the U.S. health care systems?

While there are a number of similarities between the two countries, there are several key differences. First and foremost, the Canadian health is operated under a set of mandatory, minimum requirements that must be followed by each province. Under those requirements, the health care system must be publicly administered, comprehensive, universal, portable and accessible. In this regard, it is unlike the United States -- which lacks a national, uniform, basic policy on health care.

The second major difference between the United States and Canada is that our system contains over 1,500 different insurers -- commercial insurance companies, Blue Cross/Blue Shield plans, federal and state plans, and self-insured firms -- in addition to one of the highest level of direct out-of-pocket payments in the world. In Canada, each province acts as the single insurer and single reimburser to providers -- the so-called single-payer system -- for covered services. (Private insurance is available to supplement the benefits provided through the provincially-administered plan.) In the United States in 1989, 42 percent of total health expenditures were public health expenditures. In Canada, 75 percent of total health expenditures flowed through public programs. (The OECD mean in that year was 78 percent).

A third major difference between the United States and Canada is that the United States -- unlike virtually every other industrialized country -- fails to set overall expenditure limits, fails to incorporate a uniform reimbursement system for physicians, and fails to set global budgets for hospitals and other institutions. In Canada, those measures are incorporated into the system, although some would argue that the fee-for-service schedules for physicians and other independent providers could be improved.

Through the single-payer system and the above-listed cost controls, Canada has been able to effect the real growth of health care spending and maintain expenditures as a fairly constant percentage of GDP. They have been able to allocate their resources more efficiently. And they have been able to avoid the multi-tier system of care found in the United States which determines health care access on the basis of income, age, race, and health status. As a result, per capita spending in Canada in 1989 was $1,683 compared with $2,354 in the United States; spending as a percentage of GNP in Canada was 8.7%, 11.8% in the United States. And, their record on infant mortality, child mortality and life expectancy (as well as citizen satisfaction) was better than ours.

Much has been made of the charges that the Canadian system, unlike that of our country, rations care. Obviously, only a few could dare to claim that care is not rationed in the United States -- it is done so daily on the basis of insurance status, income, geographic location, and even health status. In fact, unlike the Canadian system where the number of persons waiting for specialized procedures is known, we cannot even begin to put a definite figure on the number of Americans who need coronary bypasses or bone marrow transplants because many of those people have been shut out of our health care system altogether.

The Canadian system does ration care but does so based on medical need as determined by physicians. While the evidence is that there are minimal waits for emergency or primary care,

there are waits for some specialized procedures which are "urgent" or "elective" in nature. Some of those waits are due to a Canadian decision to concentrate dangerous or highly specialized procedures in "centers of excellence" -- making a sound medical decision that patients have better outcomes in facilities where physicians and other providers perform more of those procedures and thus have improved expertise. Some of those waits are due to a Canadian decision to limit the number of "centers of excellence" or the level of technology. This would likely not be a decision that the United States would make but, with a health care budget 40 percent greater than Canada's, we could easily provide enough technology under a single-payer system to avoid those waiting lines.

Financial obstacles to care -- the insecurity of knowing that an illness or accident could cause financial hardship or bankruptcy -- are also missing from the Canadian system unlike the American system. Premiums, copayments, deductibles and balance billing are virtually gone from the Canadian system. In the United States, cost-sharing requirements are on the rise.

The Canadian system -- which offers its residents full freedom to choose their own physicians, hospitals and other providers -- is, unfortunately, increasingly different from the United States in that respect. Many employer-based health care plans restrict individual choice either directly or through financial penalties for those who choose to go to providers outside an HMO or other managed care system.

The Canadian system also differs from the United States in its emphasis on research and commitment to ensuring rapid dissemination of high-tech equipment (although, as the United States' health budget is further strained, we can expect a strain on research budgets at the same time that the Canadians are pioneering new medical technologies such as lung transplants.) While some would argue that we are overcommitted to high-tech medicine -- both because of the lack of emphasis on preventive and primary care, because of the cost of unnecessary duplication, and because of the history of massive purchases of equipment that turn out to be outdated or relatively ineffective, an American single-payer system should be expected to include more funding for both research and technology.

The Canadian system differs in the relative absence of managed care facilities. While HMOs and other managed care systems have had uneven records of performance in the United States, we would expect that an American system would include them as an option.

Finally, I want to point out that both the Canadian and the U.S. health care systems suffer from a lack of consumer participation in the decision-making process. The bill that we are supporting -- H.R. 1300 -- would create a democratic decision-making process that both countries should incorporate.

2. How would you pay for a national health care system?

We believe in progressive financing for a national health care system. We also believe that, by eliminating administrative waste and unnecessary procedures, it can be done at a reduced cost. Instead of requiring that businesses, individuals and families pay insurance premiums, copayments and deductibles, and out-of-pocket costs, each sector should contribute fairly to a national Trust Fund. We believe that the financing provisions of the Russo bill, H.R. 1300, constitute a reasonable and equitable financing mechanism. Those provisions include a new 6% payroll tax (in addition to the current 1.45% HI tax) and some increases in the corporate income tax for employers, progressive income tax increases to individuals, the current 1.45% HI tax paid by workers, a monthly payment by senior citizens, and maintenance of effort provisions for state and federal governments.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Let me just—we have to go to the airport, but I think the single largest and most important domestic policy issue in the 1990s is going to be health care, the access to, the delivery system and the cost of, and I just want to thank your two representatives for bringing us here so that we could hear from the Connecticut people about your experience.

We have had one in Massachusetts. We attempted to do universal health care and frankly it has not worked out too well, but we need to put those little pieces together and come up with some sort of comprehensive system because it is a problem not only that will not go away, but I do not think the American people will let it go away because they are not going to allow millions of average Americans not to have access to a health care system when it delivers the best system in the world in terms of care of people. The problem is affordability. It's also access. Half of that is our responsibility, and appreciate you having us down here. Appreciate it very much.

Chairman STARK. I just want to thank the panel very much. Thank you. [Applause.]

Mrs. JOHNSON. It would be helpful because actually I, too, am leaving for the plane, but being more familiar with the territory, I feel comfortable leaving quite a bit later than the major group needs to leave. So if we could get started and the legislators are John Larson, Cynthia Matthews, Joe Courtney, and Sally Bolster, if you could sit down and let us get started.

I do not see John Larson. OK. John, as president pro tem of the State Senate, would you please start?

Mrs. KENNELLY. I would like to make a comment. Mr. Donnelly from Massachusetts, as he was leaving, said if I were you, I would not be leaving either in a reapportionment year if my president pro tem was coming.

## STATEMENT OF HON. JOHN B. LARSON, PRESIDENT PRO TEMPORE, CONNECTICUT STATE SENATE

Mr. LARSON. Yes, I am sure Bill Bolger would have a conversation with him when I get up to Massachusetts as well.

Thank you, Nancy and Barbara.

I certainly would like to welcome Congressman Pete Stark of California and the other members of the Ways and Means Subcommittee on Health in the U.S. House of Representatives to Connecticut today, and I am especially happy that we are able to testify as a panel before two distinguished Congresswomen from the State of Connecticut.

Not too long ago, I had the opportunity to speak at the University of Connecticut with Congresswoman Johnson, and certainly being here in the First Congressional District with our illustrious and dedicated Congresswoman Barbara Kennelly is always indeed an honor.

We are fortunate as well that she has not only distinguished herself on the State level but nationally, and certainly all of us in the events in the last several days stand by on a moment-to-moment

basis viewing the TV and want to laud her for her courageous trip to Israel and Saudi Arabia.

In many respects, it is like speaking to the choir, and I know that you have prepared testimony from us, and, so, suffice it to say and to expedite matters and knowing the time constraints that you are facing as well, I will try to summarize the remarks that we have in front of us.

Needless to say, again I would indicate that it is like preaching to a choir here because I know how familiar both of you are with the circumstances faced here in the State of Connecticut.

We are seated today in what is the old gallery of the initial State Senate here in our State House. Connecticut is, however, a State of contrast. We are conducting this hearing in the city of Hartford, the fourth poorest city in America. We are conducting this hearing in the insurance capital of the world, and there are 272,000 people in the State of Connecticut that have no form of insurance whatsoever.

And we also note now and I state later on in my testimony that there is an infant mortality rate in the city of New Haven that rivals Third World countries. Clearly, when we find ourselves in the position of being the wealthiest State in the Nation per capita, it seems that these problems that beset us should be within our reach.

The committee has been very gracious in allowing us the opportunity to come before it and express our concerns. As you may know, last year, Connecticut adopted one of the most comprehensive State health insurance plans in the Nation, an act concerning the recommendations of the Blue Ribbon Commission on State health insurance.

Seated with me today at the panel are Senator Matthews and Representative Courtney, who chaired that committee, and along with Representative Dillon, are extremely knowledgeable in the specifics of the bill.

I think it is safe to say that much like President Bush has said, that States continue to be laboratories for democracy, we like to think that the State of Connecticut has led the way in this field, and much like the way the Province of Saskatchewan led the way for other provinces within the state of—within the nation of Canada, it ultimately led to their national health policy.

The Connecticut act was adopted to stem the State's rising tide of uninsured residents, as I estimated earlier, some 272,000, who currently have both problems with accessibility and availability of health care insurance.

Far-reaching legislation was a result of hard work and careful deliberation undertaken by a cross section of individuals, most of whom you have already heard from this morning. This landmark measure aids specifically in the creation of more affordable insurance for small companies with 25 employees or less and expands Medicaid coverage to include more poor children and pregnant women. It also assists small businesses by including a number of small group market reforms designed to increase affordability and accessibility of insurance through the creation of a reinsurance pool.

The act further expands the capacity of already established community health centers to provide the basic access to essential and long-range cost saving health care services to Connecticut's uninsured and most disadvantaged residents.

Funding for this initiative will be critical to our on-going care for the poor and those with limited access to health care services. I have often stressed that it seems as though we approach problems in this State and in this Nation on the back end, much in the familiar manner of which we have seen what used to be the old Fram Oil commercial, where we are not willing to invest a small amount of money on the front end and end up having to pay a very vast sum of money to solve our problems on the back end.

It seems to me both as a State and as a nation, we should be more concerned preventatively in terms of placing our dollars. For example, we know that every dollar that we invest in the Head Start program saves us $6 down the road in remediation. The same has got to be true in the case of prenatal care for our children. We know that that is in fact the case.

The overall impact of this initiative cannot yet be measured, but considering the State and national statistics, it is easy to see the magnitude of the problem we and Government officials are trying to address.

According to a recent Hartford current editorial, the health care for children must not wait. State health officials estimate that close to 73,000 women and children in Connecticut cannot afford commercial insurance but have too much money to qualify for welfare. About 17,600 of them have no health insurance and the rest do not have what they need.

Equally staggering, of course, is what I have mentioned already, that the city of New Haven leads the Nation in infant mortality, rivaling many Third World countries.

Frankly, and I had the opportunity to listen to some of the previous discussion, I think what is needed for this Nation is a domestic Marshal Plan, and, clearly, if we have the will in this Nation as we have demonstrated in the gulf, to keep both a secure and free world, then we must as well have the will to address the major domestic problems that we face in this Nation.

Number one problem, I believe I heard Mr. Donnelly say it in his closing remarks, is that of providing universal health care access to all of our citizens. If we are going to have the will to bail out savings and loans associations across the State—across this country, then we as well have got to have the will as a nation to address the concerns of the uninsured and the underinsured.

This is one of the express reasons that Connecticut in its efforts to provide more coverage felt that it was incumbent upon our part, as you heard earlier, to work with small businesses in extending benefits to their workers.

We understood the interrelatedness of business needs coupled with the needs of the working poor, and we can all agree that a well cared for American worker is the backbone of a productive society.

I would like to thank again both Congresswomen for providing us the opportunity. I am sure that the expert and specific testimony

that you will be hearing from my other distinguished colleagues on the panel will yet be more illuminating to you.

I apologize and certainly you, I am sure, can understand that we have two legislative management meetings going on, a public hearing on ethics, and unfortunately I am not going to be able to stay with the panel, but I would certainly answer any questions that you might have at this juncture.

[The prepared statement follows:]

"Access to Health Care"
Testimony of Senator John B. Larson
President Pro Tempore
Connecticut General Assembly
Before the Subcommittee on Health
Ways and Mean Committee

February 25, 1991

Good morning. I am happy to join and welcome Congressman Peter Stark of California and other members of the Ways and Means Subcommittee on Health of the U.S. House of Representatives to Connecticut today. I am especially happy to testify before my own Congressional representative, the illustrious and dedicated Congresswoman Barbara Kennelly from the 1st District of our great state. We are fortunate that she has not only distinguished herself on the state level, but nationally and most recently internationally with her courageous trip to Israel and Saudi Arabia.

Thank you all for giving me the opportunity to speak before your subcommittee on the issue of access to health care and the availability of health insurance. This is unequivocally one of the most important issues facing our state and our nation-- and one which we have been willing to tackle.

As you may know, last year Connecticut adopted one of the most comprehensive state health insurance plans in the nation, An Act Concerning The Recommendations of the Blue Ribbon on State Health Insurance. This act was adopted to stem the state's rising tide of uninsured residents (estimated to be approximately 272,000) who currently have problems with both accessibility and availability of health care and health insurance.

This far-reaching legislation was a result of hard work and careful deliberation undertaken by a cross-section of individuals ranging from health care and family advocates to business and labor representatives, along with many other interested parties who continue to recognize the strong need to provide quality health care for all of our citizens.

This landmark measure aids specifically in the creation of more affordable insurance for small companies with 25 employees or less and expands medicaid coverage to include more poor children and pregnant women. It also assists small businesses by including a number of small group market reforms designed to increase affordability and accessibility of insurance through the creation of a reinsurance pool.

The act further expands the capacity of already established

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community health centers to provide basic access to essential and long-range cost saving health care services to Connecticut's uninsured and most disadvantaged residents. Funding for this initiative will be critical to our on-going care for the poor and those with limited access to health care services. I have often stressed that money will be wasted if we approach our problems through remediation rather than prevention. Back end solutions to any problem always prove to be more costly.

Though the overall impact of this major initiative cannot yet be measured, citizens of the state of Connecticut were in full agreement on the severity of the problem as well as the need to devise innovative and creative solutions to help our uninsured and underinsured residents gain access to health care and health insurance. This legislation is clearly not a panacea for a global problem that effects our state and nation, but we feel confident that it is a first step in the right direction.

Considering state and national statistics, it is easy to see the magnitude of the problem we as governmental officials are trying to address. According to a recent Hartford Courant editorial entitled "Health Care For Children Must Not Wait", state health officials estimate that close to 73,000 women and children in Connecticut cannot afford commercial insurance, but have too much money to qualify for welfare. About 17,600 of them have no health insurance and the rest don't have what they need. Equally staggering is the fact that in our own state of Connecticut, the city of New Haven leads the nation in infant mortality, rivaling many third world countries.

To this end, I have concluded as have many of our public officials that it is incumbent upon the federal government to adopt a national health care insurance policy to address the needs of the overwhelming number of Americans who go without medical attention due to the lack of health insurance.

Establishing such a plan will no doubt be a challenging and difficult task but the increasing numbers of Americans caught in this web of despair often produced by poor nutrition and insufficient care is indicative of our need to adopt a cost effective and thoughtful plan to confront this problem. As your release indicates the problem is of mammoth proportions with over 33 million Americans presently with no health coverage.

If we are to continue to have a strong and productive workforce and robust economy, we must strive to make availability and accessibility to health care a top priority. We also have a responsibility not to view these concerns in a vacuum. This is one of the express reasons that Connecticut in its effort to provide more coverage worked out a compromise to aid small businesses in extending benefits to their workers. We understood the interrelatedness of business needs coupled with the needs of the working poor. We can all agree that a well-cared for American worker is the backbone of a productive society.

Again, thank you for providing me with this opportunity to appear briefly before your distinguished subcommittee and I will be happy to address any question you may have regarding Connecticut's health policies.

Mrs. KENNELLY. Senator Larson, I would like to take the opportunity to thank you and your staff, particularly Lorraine Gilmartin, for the incredible help they have given us in arranging this meeting and letting us use this area. We really appreciate all the help that you have given us.

Mrs. JOHNSON. Thank you, Senator Larson, and let me just clarify for the rest of you that your complete statements will be included in the record. So you have a right to discuss aspects of the problems that perhaps have not been addressed earlier and that your experience would give you special insight into.

Also, I might remind you that our Ways and Means staff are here, and in Washington, they drive the work and the analysis of the issues quite significantly. So while there are not as many member chairs taken, there are some very significant chairs being occupied that will assure that your comments are not only part of the record but part of the discussion of the subcommittee.

Mr. LARSON. I think all of us understand the press of legislative business and certainly with committee meetings currently going on over in the Legislative Office Building, we understand the time constraints that you are operating under as well.

Mrs. JOHNSON. Thank you.

Mr. LARSON. Thank you very much.

Mrs. JOHNSON. Cynthia. Senator Matthews.

**STATEMENT OF HON. CYNTHIA MATTHEWS, COCHAIRPERSON, CONNECTICUT HEALTH CARE ACCESS COMMISSION, CONNECTICUT STATE SENATE**

Ms. MATTHEWS. Thank you.

It is certainly my pleasure to be here with our two Congresswomen. We are very proud, and we are very pleased today that you were able to arrange this meeting because, as you can see, we are very interested, and we are very concerned. I am not going to be reading you my remarks, but simply to tell you that as the senate chairman of public health, chairman of the previous Blue Ribbon Commission, and cochairman with Representative Joe Courtney of the new Health Access Commission, I wanted to give you some insight on why we were able to reach this particular point in our history because even though it may not be seem to you we have made dramatic improvements, we certainly were able to fuse together a very diverse group of 37 commission members, and you heard from some of them today.

And how were we able to do this? Because this 37-member commission included most of the constituency groups involved in health care. It had a preponderance of business on it and industry. It was not strictly consumers. Through a series of public hearings throughout the State, we were able to fuse a common understanding of what the needs are.

We knew that we had close to 300,000 uninsured, and because we heard testimony that was so compelling, so dramatic, we realized that we were dealing with people who were paying taxes but simply could not afford the premiums for their health care.

So we brought together these diverse people who agreed, number one, that children and pregnant women should be our first con-

cern. That was a unanimous decision. We went on from there to Commissioner Kelly, Commissioner Adams, Commissioner Aronson, and Commissioner of Human Resources Elliot Ginsberg, all came together and assisted us.

What we decided was then that we would develop a State subsidized insurance policy for children and pregnant women, that it would be a sliding scale fee, and that we would work on this with the department of health services.

Second, we knew that expanding the capacity of direct services was really essential. So what we were able to do during a tough budget year, was allocate $500,000 for our 11 community health centers throughout the State.

We then realized that many community health centers could not afford the services of doctors and health care providers, so we decided to expand on the loan repayment program that was originally designed by the Federal Government, and by putting some money in, we were able to then triple that through Federal matching contributions, so that we now have a loan repayment program that will entice health care providers, doctors, dentists, and so on, to work in community health centers.

You heard testimony about the insurance policy to small employers. We realized that 70 percent of the uninsured in Connecticut did work for small employers. We worked close to a year to plan and design the two new insurance plans and market reform.

We feel that every year, something has to happen, something some way, we have got to reduce the amount of people who are uninsured. We would like your help. We feel that Medicaid expansion may be another way to go, through Healthy Start. We would suggest that a pilot program directed to Connecticut might be very, very helpful.

We ask you to be creative as we have been. We have done, I think, a tremendous first step. We did say to everyone that everyone has got to make a contribution. We asked providers to accept 75 percent of what reimbursement they normally might accept because otherwise they would accept nothing.

We asked the hard-pressed State government to make a contribution as well. We have asked everyone to bring something to the table, and they have responded, and we would like you to respond as well.

Work with us. A pilot program, a demonstration program. We will be talking with you about it. We would love to see you be a part of this tremendous and dramatic initiative in Connecticut.

[The prepared statement follows:]

State of Connecticut
GENERAL ASSEMBLY

HEALTH CARE ACCESS COMMISSION
ROOM 3000, LEGISLATIVE OFFICE BUILDING
HARTFORD, CONNECTICUT 06106

SENATOR CYNTHIA MATTHEWS
CO-CHAIRPERSON

REPRESENTATIVE JOSEPH COURTNEY
CO-CHAIRPERSON

TESTIMONY FOR U.S. WAYS & MEANS, HEALTH SUBCOMMITTEE

DATE: February 25, 1991

FROM: State Senator Cynthia Matthews

PLACE: Hartford, Connecticut

RE: access to health care & health insurance

Introduction:

Good morning, I am State Senator Cynthia Matthews, of the 9th District and I am testifying in my capacity as Senate Chair of the CT Health Care Access Commission as well as of the Public Health Committee.

I am pleased to acknowledge the other invited speakers and legislators present today that serve on the Health Care Access Commission and/or the previous Blue Ribbon Commission On State Health Insurance: State Representative Joseph Courtney (HCAC & BRC co-chair); State Representative Norma Gyle (member BRC); former Health Department Commissioner Frederick Adams (member HCAC & BRC); and Mr. Craig Leroy (member HCAC).

Testimony Outline:

For my testimony today, I will briefly describe the history and process of the Blue Ribbon Commission On State Health Insurance. Then I will outline some of the final Blue Ribbon recommendations of a package approved by the General Assembly (Public Act 90-134) and review the accomplishments and difficulties in the planning and implementation of those initiatives. My Commission co-chair, Rep. Courtney will describe the remaining portion of the Blue Ribbon initiatives. Finally, I will review some concerns and recommendations for the near future.

History & Process of Blue Ribbon Commission:

The Connecticut Blue Ribbon Commission On State Health Insurance was established in recognition of the undeniable health needs of the hundreds of thousands of medically uninsured who are not insured by the public or private sectors. The state commission formed in the absence of substantial federal action on this nation-wide public health problem.

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The bipartisan, diverse composition of the 37-member Blue Ribbon Commission was an essential factor in the Commission's success in developing the package of health policy recommendations which received equally strong endorsement by the insurance industry, consumer activists, health providers, as well as large and small business. The Commission members all recognized that there are a multitude of causes contributing to the problems of the medically uninsured and of the health care system. Therefore no single constituency could be blamed and each member was invested in contributing to a Commission consensus proposal package.

After much deliberation the Commission developed a package of recommendations, now in Public Act 90-134, with a public-private partnership approach, to begin achieving health care access for all.

Description & rationale: children & pregnant women initiative

Early in its deliberations, the previous Blue Ribbon Commission and the ongoing Health Care Access Commission identified children and pregnant women as a high priority. The Commission recognized that these populations have special health care needs and that it is very cost effective to provide health care to them.

This proposed state subsidized individual insurance initiative which is neither an entitlement program nor an employment based product will assist non-Medicaid eligible pregnant women with incomes below 250% of federal poverty and children in families below 200% of poverty ($25,400/family of four).

This population is not being served in the existing patchwork health care system. 1/4 of the uninsured are children and pregnancy is still included as a pre-existing condition exclusion. An unfortunate consequence of being uninsured is that this population is likely to delay or forego preventive care such as prenatal care and well child care, a precursor to significant and expensive medical problems in the future. The high infant mortality rates in cities such as New Haven and Hartford is evidence of the magnitude of the problem The eventual treatment of the resulting medical conditions such as neonatal care and unnecessary childhood illness drives up the costs of the health care system for all payors because such treatment is usually unafforadable by the uninsured patient and therefore becomes a part of the growing debt that is shifted to other payors to account for this uncompensated care.

An addition to consumer activists, the insurance industry has been supportive of the program even though this industry traditionally dislikes public intervention.

Planning & development: children & pregnant women:
The state health department has hired a consultant to devise demonstration program options that are being reviewed by the Health Care Access Commission. The Robert Wood Johnson Foundation has expressed an interest in this program.

The Commission's primary concern is that even though this priority program will save health care dollars in the near and far future, the state with its severe budget difficulties, may not be able to sufficiently fund this program.

Community health centers:
The Blue Ribbon Commission recognized the need to expand the capacity of already established community based primary care centers to provide basic access to essential and cost saving services to Connecticut's uninsured and most disadvantaged residents. The eleven health centers are located in federally designated medically underserved areas. The Commission as well as Governor Lowell Weicker have recognized that community health centers are a wise investment in that they meet basic health needs which reduce potential hospitalizations for treatable, manageable or preventable conditions. $500,000 in grants and $258,000 in bonding has been provided to the community health centers.

Unfortunately the centers' capacity cannot meet the demand for services. Additionally there remains a significant population of uninsured and medicaid patients that do not reside near any community health center and cannot afford health care in their local area.

A state loan repayment program was also recently established to assist the community health centers in recruiting needed clinicians to serve in the centers which are unable to offer saleries competitive to the private practice of medicine. This loan repayment program is now three times larger due to the granting of federal funds to the health department resulting in a total of $120,000 for this year.

Concerns & recommendations:
Even though the development and legislative passage of the Blue Ribbon Commission's package of "first step" recommendations was a laudable accomplishment; those initiatives, once they are fully implemented, will still leave a large portion of the uninsured uncovered. Particularly with the recent recession and the increase in unemployment, it is clear that the states cannot solve this daunting problem alone and eventually a nation-wide solution will be needed. Yet considering the federal budget deficit and the political aftermath of the Medicare Catastrophic legislation, I do not expect comprehensive federal health care reform in the near future.

In the short term I urge the federal government to not reduce funding for Medicare which would result in an increased burden on other payors in the health care system.

I also would encourage you to examine the various state proposals and models for health care reform. There are some messages that the Blue Ribbon experience can offer to this congressional subcommittee. First, the resolution of the problems of the medically uninsured should not be postponed, because delay increases the medical casualties and costs in the health care system. Second, successful health planning must involve the many constituency groups inherantly involved in health care and insurance. Third, health policy reforms should have at least a dual focus on health insurance and health services because insurance, such as medicaid, does not guarentee access to health care. Fourth, as Rep. Courtney will soon describe, the Commission strongly agreed that mandates on small businesses would not resolve, but could exacerbate, existing health care problems. Connecticut will soon test the value of voluntary, new, small business insurance policies and market reforms.

I will conclude by stating that I am glad to see that the committee has recognized the seriousness of this public health problem by initiating these public hearings. I would be pleased to answer any questions or if you would like additional information in the future please feel free to call me (203) 240-0560. Thank you for the opportunity to present testimony today.

Mrs. JOHNSON. Thank you very much, and Barbara is going to take over the rest of this hearing because I do have to leave in order to make my 4 o'clock meeting in Washington.

Thanks. Thanks, Barbara, for all your help.

Mrs. KENNELLY. Thanks, Nancy.

The Honorable Sally Bolster will testify next.

## STATEMENT OF HON. SALLY McCARTHY BOLSTER, CONNECTICUT HOUSE OF REPRESENTATIVES

Ms. BOLSTER. Thank you, Congresswoman Kennelly.

My name is Sally McCarthy Bolster. I am a State representative from the 137th, which is in Norwalk, Conn., and I am the Republican ranking member of the Connecticut General Assembly's Human Services Committee.

Last November, I was privileged to attend the Colloquy on Health Care Ethics in Charlottesville, Va. The conference was sponsored by a few charitable trusts and was arranged by leading health and ethics academicians from the University of Virginia and the University of Nebraska's medical center.

The invited participants were one legislator from each State, and there were 40 States who attended from Hawaii to Maine. It was an intensive week of workshops and discussions with very diverse views, I can assure you, but the most amazing outcome of this conference, when you consider all the people who were there, from urban and rural areas, agricultural, manufacturing, North, South, the whole bit, that we, State legislators, all agreed on so many things.

We found that we shared more problems than we differed on, and I just wanted to present to you some of the conclusions that this group made.

First, we recognized the Federal Government has the preeminent role in financing health care for the poor, but we also realized that the States are on the front line, and we see every day in our cities and towns and on our farms and in our factories the tremendous burden facing so many of our constituents. The inability to access basic health care.

And we as State legislators agreed that our National Government must provide us some flexibility in redesigning the delivery of health care.

We all know the problem, but this group of legislators wanted to try something new, something innovative. Everybody wants good accessible health care, but nobody agrees on how to do it. Our Federal system is comprised of States which are often referred to as the laboratories of democracy and each State has different ideas. Some will be successful and some will not.

Some initiatives will become models for further development and some experiments will fail even under the best of conditions, but we must try and through experimentation and innovation of the many States solutions will evolve. We can find the answers to the problems that plague us.

But if the States are to perform this constitutional role, we must have help from our Federal partner. Currently, some Federal laws and regulations severely restrict the States' ability to experiment

with programs that could preserve essential services and increase access to basic health care for the uninsured, the underinsured, and the uninsurable.

The States were not asking for blanket waivers or exemptions. They only asked Congress to look favorably on a State's request to try a new approach. The status quo is no longer acceptable.

This diverse group of legislators argued strenuously over the best means to improve health care access, but the overwhelming concern for the millions of uninsured people in our respective communities produced the unanimous desire to forge ahead on the various solutions.

Access to health care is the most pressing and immediate problem facing our Nation. We believe that universal access must be provided through alterations and adjustments to the existing private-public insurance system.

A great deal of our national focus today is how our multipayer system might evolve into some form of a single-payer system, but we should begin immediately to institute changes in policy and practices to improve the efficiency of our existing system.

We should expand our alternative and out-patient services. We should expand appropriate screening and community-based alternatives for long-term care. Home care options should be increased. Health care delivery systems should be streamlined, and health education and prevention should be more widely available.

We must encourage the development of case management, applicable and useful data systems and the extension of nonphysician health care professionals. We also felt that there ought to be some insulation against too many of us politicians influencing the overall design of our health care delivery system, and we believe that nonelected health policy specialists must play an important role.

We also believe that the extension of health care access should be financed through a combination of personal, private and public sources. It is imperative that every employee beneficiary pay a reasonable share of their own costs as a means of limiting utilization and generating revenue.

Private employer-based insurance is an important part of our system, and public assistance should help those who have a genuine financial need. Although equal access to basic health care is the right of all citizens, the intense pressure and growing demands now in our health care system are likely eventually to force a rationing system of some sort.

The allocation decisions should be based on the widest public benefit and the quality of life enjoyed by the majority of citizens. Any allocation formula or policy should be made only with the broadest possible public participation, discussion and determination, and any priorities that are established should focus as well on beneficial outcomes for patients as well as the total impact on society.

As we go forward in crafting a new equitable health care delivery system, we must consider the problems associated with society's newest scourge, AIDS. We must continue to fund AIDS research to the best of our ability and expand education programs.

And AIDS education must be made available to all students, including the very young, and it must deal frankly and directly with

sexual and drug abuse practices. We should institute anonymous, confidential, voluntary testing and expand our counseling.

These were some of the conclusions of this group of State legislators. They were of both political persuasions, and they came from all across the country, but they all agreed on these items, and that by working together, we can craft a new and better health care delivery system.

We will have to do some experimenting. We are going to face some risks, but in the end, together, we can forge a new system and one that will benefit everyone.

[The prepared statement follows:]

**STATEMENT OF SALLY McCARTHY BOLSTER, STATE REPRESENTATIVE FROM THE 137th DISTRICT, NORWALK, CONN.**

My name is Sally McCarthy Bolster, State Representative from the 137th District in Norwalk, Connecticut. I am the Republican Ranking Member of the Connecticut General Assembly's Human Services Committee. I appreciate your inviting me to testify before you today on this very important issue -- access to basic health care.

Last November, I was privileged to attend a colloquy in health care ethics in Charlottesville, Virginia. This conference sponsored by the Pew Charitable Trust was arranged by leading health and ethics academicians from the University of Virginia and the University of Nebraska Medical Center. The invited participants were one legislator from each of 40 states from Hawaii to Maine. It was an intensive week of workshops and discussions with diverse views from the participants who represented such a cross-section of our country - urban, rural, agricultural, manufacturing, north and south.

The most amazing outcome of this conference was that we, state legislators all, agreed on so many things. We found that we shared more problems than we differed on. This morning, I should like to present to you some of the conclusions we reached - at least as I viewed them.

First, we recognized that the federal government has the pre-imminent role in financing health care for the poor. But we also realized that the states are on the front line. We see everyday in our cities and towns, on our farms and in our factories, the tremendous burden facing so many of our constituents - the inability to access basic health care. And we, as state legislators, agreed that our national government must provide us some flexibility in redesigning the delivery of health care.

We all know the problem - clogged hospital emergency rooms, closed rural hospitals, inadequate basic preventive care. All these problems while we face an anticipated national expenditure for health care of $660 billion in 1991.

This group of state legislators wants to try something new - something innovative. Everyone wants good, accessible health care, but no one agrees how to provide it.

Our federal system is comprised of states which often have been referred to as the "laboratories of democracy". Each state has different ideas - some will be successful, some will not. Some initiatives will become models for further development. Some experiments will fail, even under the best of conditions. But we must try. Through experimentation and innovation of the many states, solutions will evolve. We will find answers to the problems that plague us.

If the states are to perform this constitutional role, we must have help from our federal partner. Currently, some federal laws and regulations severely restrict state's ability to experiment with programs that could preserve essential services and increase

access to basic health care for the uninsured, underinsured and uninsurable.

The states are not asking for blanket waivers or exemptions. They only ask Congress to look favorably on a state's request to try a new approach. The status quo is no longer acceptable.

This diverse group of state legislators argued strenuously over the best means to improve health care access. But the overwhelming concern for the millions of uninsured people in our respective communities produced an unanimous desire to forge ahead on various solutions.

The U.S. is facing economic and ethical problems. Choices will be required in order to provide effective health services.

Access to health care is the most pressing and immediate problem facing our system. These state legislators felt that every individual should be assured access to basic health services.

Such universal access should be provided through alterations and adjustments to the existing private/public insurance system. A great deal of our national focus today is how our multi-payer system might evolve into some form of single payer system, but we should begin immediately to institute changes in policy and practices to improve the efficiency of our existing system.

Specifically, we should expand our alternative and out-patient services; appropriate screening and community-based alternatives for long-term care should be instituted; home care options should be increased; health care delivery systems should be streamlined; and health education and prevention should be more widely available. We should encourage the development of case management, applicable and useful health data systems and the extension of non-physician health care professionals.

There also should be some insulation against too much political influence in the overall design of our health care delivery system and non-elected health policy specialists must play an important role.

The extension of health care access should be financed through a combination of personal, private and public sources. It is imperative that every employee-beneficiary pay a reasonable share of their own costs as a means of limiting utilization and generating revenue. Private employer-based insurance is an important part of our system and public assistance should help those with genuine financial need.

Although equal access to basic health care is a right of all citizens, the intense pressure and growing demands now on our health care system are likely eventually to force a rationing

system of some sort. Allocation decisions should be based on the widest public benefit and the quality of life enjoyed by the majority of citizens. Any allocation formula or policy should be made only with the broadest possible public participation, discussion and determination. Any priorities that are established should focus as well on beneficial outcomes for patients as well as the total impact on society.

As we work to establish equitable access to health care for all our citizens, we must recognize that each of us has the right to live and die with dignity by having our individual wishes honored, whether by availing ourselves of such tools as living wills, advance directives, durable powers of attorney for health care, or by making our wishes known to others including family, friends, clergy and providers.

As we go forward in crafting a new, equitable health care delivery system, we must consider the problems associated with society's newest scourge, AIDS. We must continue to fund AIDS research to the best of our ability and expand education programs. AIDS education must be made available to all students, including the very young, and it must deal frankly and directly with sexual and drug abuse practices. We should institute anonymous, confidential and voluntary testing and expand counseling. We must develop a practical system of identifying, treating and assisting AIDS patients at the earliest possible time following diagnosis.

These were the conclusions of this group of state legislators. We must work together to craft a new and better health care delivery system. We will have to do some experimenting; we will face some risks, but in the end, together we can forge a new system - one that will benefit all our citizens.

Mrs. KENNELLY. Thank you for that excellent testimony.
Pat Dillon, Representative Dillon, is next.

**STATEMENT OF HON. PATRICIA DILLON, CHAIR, PUBLIC HEALTH COMMITTEE, CONNECTICUT HOUSE OF REPRESENTATIVES**

Ms. DILLON. Thank you, and thank you for your patience. I have a lot of competing meetings myself today. So I understand it is very difficult to keep people here.

We are very proud of our efforts to improve access to health care for everyone in this State, but my remarks will focus on the relationship between cost containment and the access to care, and on the role which the Federal Government could potentially play to improve access to quality care for all Americans.

As you are aware, the Federal Government has embarked on a major effort to contain rapidly escalating costs in Medicare, and this has been largely successful, notably in the area of hospital costs.

However, constraining costs in only one sector of the health care system does not automatically constrain costs systemwide as you have heard today. Quite the opposite. The cost of health care nationwide continues to climb.

The results of constraining costs in only one sector threatens to create a two-tier system of care. For example, there is as yet no evidence that seniors are receiving inferior care as a result of cost containment in the Medicare system, but there is a question that any hospital, for example, which serves a large number of seniors is seriously compromised in its ability to serve the uninsured. The hospitals in our own State of Connecticut which have experienced financial difficulty have been those which serve disproportionate numbers of both seniors and Medicaid patients.

So long as there are no Federal mechanisms to contain costs systemwide, providers of care to seniors and the uninsured are compromised, and your own efforts to contain Medicare costs are compromised as well because the cost of Medicare may well be carried up in the spiral of costs.

The lack of Federal mechanisms to contain costs systemwide also limit access to health care in the private sector. Although the costs cannot always be quantified at any given time, it is clear that so long as there is a gap between the reimbursement from Medicare and the overall cost within the health care system, the difference will be shifted on to the private payer. This further drives up the cost of private insurance, making it less affordable to employers and beyond the reach entirely of individuals.

In response, the private payers intensify their efforts at cost containment, which in turn pressures the hospitals. When private payers become more efficient at containing costs, the results can be punitive to those hospitals which reach out to provide quality care to seniors and to the uninsured.

Here on the State level, we find ourselves endlessly rearranging the components of a system which is fundamentally askew. We are attempting here to contain costs and to expand access at the same time. This is not impossible. In fact, it is very possible, but it is

very, very difficult without Federal mechanisms for cost containment which apply systemwide.

One aspect of Federal cost containment is, however, inherently unfair, and that is Medicare's own refusal to pay its share of uncompensated care. While other Federal policies can be justified on the basis of cost effectiveness, this one policy is arbitrary and shifts burden to other parts of the system which we feel acutely here on the State level.

In reimbursing providers, our current system of reimbursement for health care providers rewards procedures rather than clinical skills. The Federal Government, and your committee has played a role, I believe, has made major advancements by adjusting its reimbursement assistance so the primary care-givers will no longer be punished. Again, this affects only Medicare. This is not a systemwide reform. Private payers may well continue to reward technology at the expense of other treatment, driving up costs with an unclear impact on health.

While the Federal role in health care finance is decisive and clear and much debated, there are other roles that the Government can play. You have heard testimony today about Connecticut's commitment to expanding access to care for the uninsured. We are also one of the States which provides aid for prescription drugs for seniors. As you know, medication can improve the health of seniors who are at home and reduce their hospitalization and institutionalization, yet it is not covered by Medicare or by most providers. We are fully committed to improving the health of seniors and reducing their financial burden, but we do not know that all of the medications improve the health of seniors.

As you may know, seniors are routinely excluded from clinical trials for new medications, yet seniors are more likely to be taking multiple medications than the general population. In addition, as we age, kidneys become less efficient which means that medication stays in our systems longer. You on the Federal level have the ability which we do not to direct research dollars to evaluate the impact of medication on seniors, how different medications interact, whether certain seniors should not take some combinations of medication. For example, in the past few years, researchers have looked at the frequency of hip fractures in seniors in nursing homes. They have found seniors on heavy sedation were much more likely to be injured. This is a major eye-opener. Are people getting hurt because they had more problems to begin with, for example, dementia, or are we over-medicating these people?

States, especially ours, right now lack the resources to do ongoing research. The Federal Government has mechanisms in place, you also have the data from Medicare. Seniors may have been excluded from clinical trials for good reason, but we can make up for this by using data from our own programs.

This may seem a side issue in a discussion of health care access. It is not. The bottom line is that we should be providing care to all of our citizens in an equitable way, but we should be providing quality care. We are fully committed to quality care for seniors, but we need the tools to evaluate the care that we are paying for now. Is it cost efficient? Does it actually improve people's health?

The concept of national health insurance has been on the national agenda since the Bullmoose Party. Yet, all signs are that it is unlikely Congress will take on this issue this session. We in Connecticut will be facing this year an almost unprecedented situation, a dramatic increase in the uninsured, coupled with increased costs in the system.

I, for example, have been getting calls from accountants, from lawyers, from relatively upscale white collar professionals who are members of small firms who are losing their health insurance, all within the past 90 days. So that you are going to see a whole different category of people who are among the uninsured in this State.

If other reforms are unlikely, at the very least, as your first order of business, bring some sense to our system. Establish Federal mechanisms for cost containment which are systemwide. Further reform Medicare by sharing the burden of uncompensated care.

Thank you.

Mrs. KENNELLY. Thank you, Representative Dillon.

The Honorable Joseph Courtney.

**STATEMENT OF HON. JOSEPH COURTNEY, COCHAIRPERSON, CONNECTICUT HEALTH CARE ACCESS COMMISSION, CONNECTICUT HOUSE OF REPRESENTATIVES**

Mr. COURTNEY. Thank you, Representative Kennelly.

I have written comments which have been submitted, and I will not go through them all at this late hour.

I would just like to make one small point before concluding here today, which I think Representative Bolster touched on a little bit, which is the question of the actual restrictions that exist right now on States who are trying to experiment with our health care system.

When the Blue Ribbon Commission on which I served with Senator Matthews first convened, it was remarkable to me actually how few our options really were in terms of engaging in real reform, and the reason for that, I think, is simple probably to someone like yourself and others who followed this issue, which is that the three basic streams of payment into the medical system, Medicare, Medicaid, and private insurance, are strictly governed by Federal law, ERISA in the case of the private health insurance, and really the State's ability to truly experiment in terms of either moving dollars around in the system and ultimately this issue does boil down to who pays, is quite limited.

Nonetheless, I think we did a good job with the work product of the Blue Ribbon Commission in terms of dealing with this issue and with all the restrictions that were included, but when I have my brief opportunity to appear in front of a congressional person, I would just again like to reiterate our desire to be given the opportunity to experiment.

And I know I am speaking to a person who really advocated for the State of Connecticut and the Connecticut partnership for long-term care which is an example here of trying to take the Medicaid system and private health insurance system and come up a truly affordable long-term care insurance package.

We have gotten good news from HCFA just within the last month that administratively they are approving that plan, but it is somewhat baffling to us that Congress was unwilling to do it as an act of legislation.

Again, I realize that you and all of your colleagues in the Connecticut delegation worked very hard in terms of trying to get that through, that Medicaid waiver through Congress, and I would like to again salute your efforts and simply encourage you to continue with that kind of approach which is to give the State true flexibility to be a real laboratory for social experiments.

[The prepared statement follows:]

**STATEMENT OF STATE REPRESENTATIVE JOSEPH COURTNEY, CHAIR, CONNECTICUT HEALTH CARE ACCESS COMMISSION AND HUMAN SERVICES COMMITTEE**

Introduction:

Good morning, I am State Representative Joe Courtney, of the 56th district and I am testifying in my capacity as House chair of the CT Health Care Access Commission as well as of the Human Services Committee.

I am pleased to acknowledge the other invited speakers and legislators present today that seve on the Health Care Access Commission and/or the previous Blue Ribbon Commission On state Health Insurance: State Senator Cynthia Matthews (HCAC & BRC co-chair); State Represenative Norma Gyle (member BRC); former Health Department Commissioner Frederick Adams (member HCAC & BRC); and Mr. Craig Leroy (member HCAC).

Testimony outline:

For my testimony today, I will continue where Senator Matthews left off in outlining the final Blue Ribbon recommendations of a package approved by the General Assembly (Public Act 90-134), and review the accomplishments and difficulties in the planning and implementation of those initiatives. Finally, I will review concerns for states' restricted ability to experiment with substantial health care system reforms.

Blue Ribbon Commission:

The diverse 37-membered Connecticut Blue Ribbon Commission On State Health Insurance was established in recognition of the undeniable needs of the 272,000 medically uninsured which reflect pervasive problems in the whole health care system.

After much deliberation the Commission developed a package of recommendations, now Public Act 90-134, with a public-private partnership approach to begin expanding access to health care.

New insurance & market reforms for small businesses:

The Blue Ribbon Commission recognized that 2/3 of the uninsured are employed by small businesses that do not offer health insurance. These small firms tend to be those with fewer than 25 full time employees. The Commission recommended the establishment of new small employer insurance plans, special health care plans, and small group market reforms to provide greater access and affordability. The insurance industry was active in designing these reforms. A significant characteristic of this initiative is that businesses may voluntarily purchase the policies, in contrast to a "pay or play" situation.

Public Act 90-134 requires that for a three year trial period, all small employer health insurers and HMOs offer two specific insurance policies: a small employer health insurance plan that provides middle option benefits and a special health care plan, with all of the CT mandated benefits, for uninsured employers with special provisions designed to lower the cost further for employer below 200% of the federal poverty level.

The public act creates a reinsurance pool to facilitate sharing the risk equitably among all insurance carriers. Reinsurance is basically a transaction between two or more insurers to apportion risk so that a large loss does not fall on any one insurance company.

The legislation also enacts a series of market reforms designed to protect small employers and their employees in the pricing and underwriting of all health coverage sold to groups of fewer than twenty-five employees.

The reforms include:

* The term of any pre-exisitng condition limitation cannot exclude coverage beyond twelve months following the effective coverage date. It can only relate to conditions revealing themselves during the six months prior to the coverage date.

* All health insurance plans are now required to be guaranteed renewable with the exceptions of fraud, failure

to pay premiums, or when the contract holder is no longer active in the business which it was on the plan's effective date.

* The price of new plans and premium increases are limited to 200% of the lowest rate of a plan.

* Disclosure is now required for all conditions under which rates may change due to claims or health conditions.

Presumptive eligibility to Medicaid:

This Blue Ribbon Commission recommendation would allow qualified health providers to make a preliminary determination of a potential patient's eligibility for medicaid prior to actual program eligibility determination. The Commission endorsed this program for all applicants but with an emphasis on pregnant women because the presumptive eligibility ensures that important prenatal care is not delayed solely because a medicaid eligible woman has not obtained a medicaid card.

Unfortunately the Department of Income Maintenance is experiencing computer systems contraints due to the data processing of system modifications required by recent federal mandates. Therefore program implementation will be delayed.

Model 2176 "Katie Beckett" Medicaid Waiver:

This waiver permits the state, through medicaid, to provide community-based medicaid benefits and case management services to disabled children and adults who may otherwise require care in an institution.

Before Public Act 90-134, Connecticut restricted the number of persons participating under the waiver to fifty persons, the waiver was expanded seventy slots including the Governor's recent reduction of the expansion.

The Commission recognized that the waiver's expansion would not entirly represent new state spending, since some of these persons on the waiver's waiting list would otherwise be institutionalized and on medicaid.

Concerns & recommendations:

Given the long-term federal deadlock on the national budget deficit plus the political aftermath of the Medicare Catastrophic legislation, it seems unlikely that the federal government will undertake comprehensive health policy reform in the near future. At the same time, considering that states' action to increase access to health care and health insurance has been motivated by the lack of substantial federal action on this problem, it is clear that states will need flexibility to experiment with new models of health care system reform. Presently, the federal medicaid, medicare, and ERISA regulations tightly limit states ability to function as laboratories. For example, universal/unitary models have been seriously discussed in Connecticut and New York as well as innovative long-term care proposals, but if a state decieded to experiment with these options a special federal waiver would be required.

Since the different health care constituitency groups are generally anxious to move forward with new ways to increase access to adequate health care regardless of ability to pay, I would urge the federal government to grant flexibility to the states. I do also advocate that the government should refrain from cutting existing health care budgets. I applaud the recent medicaid expansions, effective in the year 2002.

I will conclude by stating that I am pleased to see this subcommitee recognize the significance of the need to expand access to health care in the United States by initiating these public hearings. Thank you for the opportunity to testify today. I would be pleased to answer any questions or if you would like additional information in the future please feel free to call me (203) 240-0490.

Mrs. KENNELLY. Well, that brings up a subject that I would like to ask you about.

I tried to get that waiver and spent incredible numbers—hundreds of hours to get that waiver through the legislative process, and as you know, I was not able to and had to go in another direction.

But one of the reasons for that was that the particular chairman of the committee with jurisdiction really felt that there was no reason to have the private insurance companies involved in long-term care programs, and that was one of the reasons I was not able to get relief.

How do you handle this question that I often get, you heard testimony this morning; how can you not support some of these proposals even if they do put people in Connecticut insurance companies out of work?

We do see some plans being proposed that do put the insurance companies out of business. Now, I know that we happen to have more insurance companies than most people. That is why we are called the insurance capital of the world, but there are other large insurance companies across these United States, and one has to think that over the years, the insurance companies did provide health care for people historically in this country and were successful.

Having said that, I will also tell you that I have been terribly disappointed very often by the lack of their response to the needs of people, and the problems that result when people cannot get the type of policy at the price that they are able to pay. And yet, I have to say to you that if in fact you choose a system does not have a piece in it for the private insurance companies, thousands and tens of thousands of jobs would be eliminated not only from Connecticut but from across this Nation.

Could you help me? How do you answer that? I get this presented to me constantly. Mrs. Kennelly, you come from Hartford, therefore you want to protect those insurance companies, end of story.

How do you answer this question when it came up in your Blue Ribbon Commission? Could you help me, share with me how you answer this?

Mr. COURTNEY. Well, again, the easy answer from the Blue Ribbon Commission was that we could not have put the private health insurance industry out of business even if we had wanted to because of the restrictions that States are under from Federal laws. So that was sort of the easy answer.

It is my feeling that after the public hearing process and the review of all the information, that the private health insurance industry in essence has broken down for the small employer and the small purchaser of health insurance, and as a practical matter, it just seems to me that either we fix that problem real fast or we are going to be in the position where the political power of this issue is going to come up with another solution other than the private market, and I at this point feel that we should give the company—the industry the opportunity to come forward with the kind of reforms that they did at the small group market to see if we can put

that back in place where it will truly function for the benefit of people.

But there is a limit to the patience of all of us in terms of just allowing the situation to go unaddressed.

Mrs. KENNELLY. Sally.

Ms. DILLON. I assume that—are you referring to the Canadian system by that——

Mrs. KENNELLY. There are numerous proposals that really have the Government as the payer and the provider as the major basis of the entire system, running from beginning to end.

Ms. DILLON. Well, as the dimensions of the AIDS problem started to emerge a couple of years ago, there were many thinkers who thought that private payers would be bailing out of the health insurance all together and that has not happened.

So that I think that there has to be a role to play for the private insurers in this country, if not in Canada. We certainly have a depth of experience on the utilization. They can play a very decisive role in terms of measuring outcomes, which they are only starting to get into, and for that reason, I think that that is something that we have to be creative about.

I would not have thought 10 years ago, looking at what is happening in Washington State, for example, that the majority of Americans would be moving toward managed care systems where their choices of physicians are restricted.

So that what I would have thought 10 years ago would be the nonnegotiable expectations of the American public have shifted very radically, so that I do not think that there is any question but that the private payer should play a role, and I would single out, though, utilization.

I do not think, though, depending on what mechanisms that you would want to adopt, if you were going to have a fixed fee schedule for providers, for example, that that would necessarily create a problem for them. A lot of the might welcome that.

So that I really think that everything should be on the table in that regard and that they would have a very important role to play.

Mrs. KENNELLY. Well, I think that is one of the reasons I literally insisted on having this hearing and thought this was a place to start because I go along with Representative Courtney.

Mr. COURTNEY. Right.

Mrs. KENNELLY. Representative Courtney, I think the situation has come to such a crisis point that I really want to bring it home to our own insurance city how people feel about this whole thing.

That is one of the reasons we kicked it off in Hartford, Conn., to show that what you just said, Pat, everything is on the table.

Ms. MATTHEWS. I think every one would agree that the ideal is for every man, woman and child in the country to have access to health care, but in order to reach that, we are going to have to make some incremental steps, and I think it is—we should enlist the help of the insurance industry, just as Commissioner Kelly turned to them and said, a policy for small employers is very much in order and we would like you to design something for us.

In other words, in order to get to that ultimate goal, we have got to use all the resources that we have. Obviously, the insurance in-

dustry is right there on the front line, and I think that you are going to see a change in the kind of policies they are offering. They have already instituted reforms because they realize that the insurance industry needs to be their friend and not someone on the other side.

I think that until we can reach that point when the Federal Government can step in and really provide what we are lacking as far as resources go, the insurance industry is going to have to be our ally and our partner.

Mrs. KENNELLY. Thank you.

Sally.

Ms. BOLSTER. This is something that was discussed at great length in Charlottesville.

Mrs. KENNELLY. I thought it might have been.

Ms. BOLSTER. You can understand that mine was probably the strongest voice for the insurance companies considering my home State, but I will say there was a lot of support even from across the country, that every one except Massachusetts thought that it should be a private-public partnership arrangement, and, of course, the Oregon plan has, you know—their suggestions, their proposals which were turned down by the Federal Government, so they could not get any waivers, so they have not been able to try out their plan, whether it is the best plan in the world, I do not know, but neither does anybody else until they are given the opportunity to experiment.

And the same is true with Colorado, that also wanted to experiment with some—a new way of delivering health care insurance.

I think we are going to have a little bit of everything. I think it is probably just as well if we do a public-private partnership, we are more inclined to be watching out for each other, too. If you put it all in one pot or all in the other, I think one or the other is going to run away with it, and that does not necessarily lead to the best delivery of service.

The 40 States that were represented in Charlottesville agreed unanimously that every one was entitled to some basic health care. Now, what is basic is the number one question. I do not think it included marriage counseling, but there were some things in the middle as to if we are to provide health insurance for everybody, first of all, we have got to decide what is basic health insurance, and what is it that we must provide that everybody should have access to.

We all agree on prenatal care, you know, and pediatric care, et cetera, but then you can get beyond, and I think that that is an extremely important question that we have got to determine by going out and talking to the citizens across this country.

Now, Oregon, I guess, is probably finished all their hearings. They were doing them all over the place to try to put together their priority list. It would be interesting to see what they come out with, and I understand that Colorado was trying to do a somewhat similar thing, and I think that it would be great if we could find out what do their people say, you know, where are they coming from.

Mrs. KENNELLY. Well, I will tell you we have been getting more requests for your small business piece. It has become well known

across the country. It is a success, and I really think it is helping to improve the image of the insurance companies because they did prove they could do something if they had to do it.

So I thank you for that, but this is something that—and even the people who have sat through this whole hearing, and I thank them so much for it, you can see that we still have not even gotten to the point of saying how do you pay for this new program, and is it comprehensive or is it catastrophic. All those questions which have to be sorted out, but I think what you see is a demand by the people of the United States of America that their public officials resolve this, and I commend you for beginning it with your commission. I promise you that it is not going to go away in Washington.

Thank you very much.

Ms. BOLSTER. Thank you.

[Applause.]

[Whereupon, at 1:53 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

## STATEMENT OF PAUL COUSINEAU, WEST HARTFORD, CONN.

Quite obviously Connecticut will finally get it's income tax. Now, when do we get a national health program. Most of us, I included, have a horror tale to tell resulting from our present health care system. We read that the patient should beware. We read that 40,000 people in America die from profit health care each year. We read that hospitals are funded by holding companies. In other words by big business. And we know where big business is concerned lives are expendable. Money for a national program could be had by raising Social Security taxes.

TESTIMONY OF
CONGRESSMAN SAM GEJDENSON
Before the
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
FEBRUARY 25, 1991
REGARDING CONNECTICUT HEALTH INSURANCE PROPOSALS

Mr. Chairman, I first would like to commend and thank you for holding this hearing in Hartford, Connecticut. In addition, I would like to thank Congresswoman Kennelly for her efforts to bring you here to hear the views of representatives from all sides of this important issue.

I am sure that we are well aware of the vast number of individuals - the poor, the unemployed, the working uninsured, and in fact, the many children - who are without health insurance coverage. Currently, an estimated 32 to 37 million individuals live on a day-to-day basis without a medical safety net. They can not afford visits to the family doctor, have no access to preventive care, no means to obtain pre-natal care, and no protection in case of a medical emergency. Twenty-four million of those uninsured are employed, working in small businesses, or in low-paying, high-turnover jobs in service industries. Others are self-employed, or are employed in seasonal occupations, such as construction and agriculture. In addition to the thirty-seven million individuals who are uninsured, there are an additional seventeen million individuals who have inadequate health insurance coverage for their needs.

As health costs increase, and care for the uninsured further strains hospital emergency rooms and health care clinics, the burden will grow greater for the thirty-three million Americans who do participate in individual health care plans. Individual Blue Cross/Blue Shield premiums in Connecticut alone have grown by 15-20% in the past year; much of this increase comes as a result of cost-shifting to private payers to pay for those who are without insurance. As costs go up, more and more people will find it impossible to keep paying their premiums. Businesses are also finding profits crunched by the rising costs of health insurance.

In Connecticut, legislators have already grappled with these difficult problems. On May 17, 1990 a law was passed enacting provisions proposed by the Blue Ribbon Commission on State Health Insurance. As many as thirty-seven disparate groups were involved in the drafting of this legislation, ranging from citizen-action groups to insurance industry representatives. Connecticut is working to provide quality, low-cost options for small businesses. In addition, Connecticut officials are working to provide a state-subsidized health insurance policy for pregnant women and children not currently covered by the Medicaid program. This is a significant step toward resolving the health access crisis on a state level. First, I would like to commend my colleagues in Connecticut for all of their efforts in this area. As well, I would encourage legislators from other states and at the federal level to give this legislation close consideration. The effort of state legislators to forge ahead and develop new strategies expanding access to health care is an indication of both the demands of an overburdened health care system and the demands of increasingly vocal Connecticut residents.

Opinion polls across the country have well documented the fact that more and more individuals are dissatisfied with rising prices of physician and hospital care, prescription drugs, health insurance premiums, co-payments and deductibles. However, I don't need to look at poll results to know that my constituents are concerned about these issues and more. Each day I get letters from my constituents which express concerns about having to choose between going to the doctor or paying the rent. Elderly individuals are worried about prescription medication costs doubling and tripling in cost. Individuals are putting off

preventive care and letting their conditions worsen.
While these problems are becoming more obvious every day, the cure is not so apparent. To improve upon our nation's health care system, it is necessary to take into consideration many complex issues. In addition to the proposals suggested in Connecticut, there are other recommendations on both the state and national level which have great merit and which I have taken into consideration. These include extending Medicare health coverage to all individuals, mandated employer insurance coverage, health care rationing, and finally, increases in the number of low-income individuals provided health care by the state-federal Medicaid program.

Congress created the Bipartisan Pepper Commission on Comprehensive Health Care to examine these various proposals and to recommend legislation that would ensure that every American would have health and long-term care coverage. The final report of the Commission, issued late last year, provides a valuable and comprehensive critique of various proposals and includes a final recommendation for legislation. However, the Pepper Commission failed to address the crucial question of cost. Who will bear the burden of cost of implementing these programs? In my mind, any proposal to provide universal access to health care for all Americans must address the matter of costs.

Connecticut's efforts to extend health insurance coverage to a greater number of individuals through innovative government-supported health insurance plans provide the inspiration and motivation to bringing these ideas to the national level.

I am currently working to put together legislation that would loosely pattern itself upon the efforts of Connecticut legislators. This proposal would create a national health care plan to provide access for each individual to health and long-term care services. Individual and family health care costs would be based on their ability to pay. Poverty level income groups would be excluded from these cost requirements. Minimum benefits would be defined to include preventive and primary service use.

One of the key goals of this proposal would be to eliminate the frustration and confusion that exist as a result of the many different insurance and government programs paying health service providers. In addition, the government would work to provide the funds for the health care costs that stem from chronic illness, devastating injury, or the fragility of age.

Financing would be achieved via two mechanisms. Individuals and families with an income beyond a certain level would pay for health care costs equaling a percentage of estimated income. Costs beyond the income cap would be government financed through taxes applied on a sliding scale basis.

My proposal envisions insurance companies playing a dual role, both as providers of supplemental insurance policies to cover the cost to the individual of the health care percentage deductible and as administrators of the government-funded comprehensive benefit program beyond the income deductible cap.

Working individuals and families would be able to work with both employers and insurance companies to design health insurance policies that cover the initial front-end costs of health care and provide supplemental coverage of valuable services such as alcohol and drug abuse in-patient recovery care, in vitro fertilization costs and others. Costs would be reduced for employers, and employees would be in a better position to negotiate for more specific service coverage.

For example, a dual income four-member family making $20,000 a year would pay a percentage of income, 10% in this case, towards health care costs. This would be $20,000 x .10 = $2,000. Employer-mandated insurance would pay for this percentage, and

the government would cover health costs beyond this point.

In the upcoming weeks, I will be continuing my efforts to bring this theoretical proposal out in a final legislative form. It is my hope that this addition to the growing number of national health care proposals will not only provide further ideas for discussion and critical analysis, but will lend my voice in a substantive way to the growing swell of support for a national health plan.

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONN. 06106

REPRESENTATIVE NORMA GYLE
ONE HUNDRED EIGHTH DISTRICT

6 MILLTOWN ROAD
NEW FAIRFIELD, CONNECTICUT 06812

RANKING MEMBER
PUBLIC HEALTH COMMITTEE
MEMBER
APPROPRIATIONS COMMITTEE
REGULATIONS REVIEW COMMITTEE
SUBSTANCE ABUSING WOMEN AND
THEIR CHILDREN TASK FORCE

SUPPORT LETTER: U.S. WAYS & MEANS, HEALTH SUBCOMMITTEE

DATE: February 25, 1991

FROM: State Representative Norma Gyle

RE: access to health care & health insurance

In my capacity as a legislative member of the previous Connecticut Blue Ribbon Commission On State Health Insurance, and ranking Republican member of the Public Health Committee, I am writing in support of the health care access testimony provided to you today by the CT Health Care Access Commission co-chairs, Senator Matthews and Representative Courtney.

I fully support the consensus package of Blue Ribbon Commission recommendations, now Public Act 90-134, which Senator Matthews and Representative Courtney will outline for you today.

Similar to the Commission co-chairs, I call your attention to Connecticut's new small business health insurance plans and small group market reforms which do not place any mandates on small employers. In addition to that public-private initiative, the Commission's recommended program for the state to subsidize insurance coverage for low income uninsured children and pregnant women is also an essential in responding to the inequities of our present health care system. Prenatal and well-child care are investments that will reduce the medical and financial misfortunes such as infant mortality, and neonatal care.

Even though Connecticut, like other states, is beginning to progress towards expanding access to needed health care and insurance, there is still much work left to be done by both the states and federal government as well as the private sector. I urge the federal government to consider providing flexibility and support to the various states which presently are the laboratories for health care reform.

Thank you for your attention to my comments. I would be please to provide additional information if you feel it would be useful. I can be contacted at the Public Health Committee, (203) 240-0560.

Sincerely,

Norma Gyle
State Representative

NG:hp

New Britain Area Conference of Churches

19 CHESTNUT ST., NEW BRITAIN, CONNECTICUT 06051, TEL. (203) 229-3751

2-13-91
Hon Pete Stark
(D Calif)

Dear Rep. Stark,

Although we were not invited to the public hearing to be held in Hartford on Feb 25 re: universal health care, we want to go on record as supporting a plan that would include all people (eg Canadian plan) - reduce the costs (ie paid through taxes & administered by 1 federal agency - not 2000 insurance companies) & gives good care to all. Maybe even some MDs could make only $75 to 100K/year & save some money.

Its time for a universal plan.

Sincerely, David Dyer

Rev. Dr. David D. Mellon
Executive Minister

Judith A. Briggs
Office Manager

Sr. Mary Bernadette Nowakowski, S.S.J.
Sr. Rosemary Cichon, S.S.J.
Urban Sisters Center

Rev. Fr. Hudson R. Richard
Rev. Susan E. Gregory-Davis
— Pastoral Care —
New Britain General Hospital
New Britain Memorial Hospital
Area Convalescent Homes

STATEMENT AND WRITTEN TESTIMONY
of
WILFRED REGUERO, M.D., F.A.C.O.G.

Chairman, Department of Obstetrics and Gynecology
Hospital of Saint Raphael

Project Director
"Project MotherCare"

Associate Clinical Professor of
Obstetrics and Gynecology
Yale University School of Medicine

Project MotherCare has been developed as a demonstration project because of the realization that there is inadequate access to health care in the City of New Haven.

Evaluation of census tract data which is specifically related to economic status, educational status, marital status and infant mortality, points to the fact that there is a direct relationship between low economic status and infant mortality outcomes. Educational status and the single parent family impact dramatically on these poor outcomes.

The Hospital of Saint Raphael, as part of Project MotherCare, instituted the Saint Raphael Neighborhood Mobile Clinic. This is a 58 foot tractor and trailer which goes to the impoverished areas of New Haven to deliver health care. A comprehensive prenatal package is the critical agenda for this project. In the two months that this project has been underway we have seen in excess of 400 patients, and have registered 22 new prenatal patients. The project has also embarked on a drug free program which uses acupuncture treatment for substance abusers. We have been evaluating the types of insurance and the number of people who are insured. To date we have found that only 14% of the clients accessing the Saint Raphael Mobile Clinic are uninsured.

It is clear that accessibility to health care can be something that is very real or at the least perceived to be real. In fact, it is likely that the perception of not being able to afford health care is in itself very real. The literature has indicated that the leading cause of the failure by women to obtain prenatal care is that they do not believe they can afford that care even if they are insured by Medicaid.

In actuality our health care system does not care for people who are underinsured very well. The reimbursement mechanism established for hospital care serves as a disincentive for the development of programs to meet the needs of the indigent in our society. It is clear to me that we need to direct monies towards direct patient care interventions that are structured to provide free health care. One of the questions asked most frequently about Project MotherCare is "how much do I have to pay if I go to the van". The fact that they pay nothing has caused this project to be an overwhelming success. I urge the Legislature not to embark on programs that require co-payments, means tests or any other strategies that demonstrate themselves to be retrogressive.

I would also point out that I have recently come to understand that even though I give a patient a prescription for a medication, they frequently do not get this medication because they cannot afford to purchase it. That makes the visit totally irrelevant. I would welcome a program that provides free medications for people who cannot afford to pay.

The health care legislation proposed in Connecticut would provide for the creation of insurance coverage for a variety of uninsured and underinsured citizens. This proposition will not work unless there is constructed into the program a proper health care delivery system to provide easy access for the people that need to use it. It is my view that access and delivery of health care can be done much more cost effectively if the health care delivery system is constructed in such a way as to target these citizens and provide that care without requiring up-front payments and co-payment.

There are many other issues that would require a great deal of study and time to elaborate on.

The project that we provide improves accessibility to health care, will help reduce infant mortality and demonstrate to many of our disenfranchised citizens that society really does care what happens to them.

Thank you for allowing me to present this statement to the Subcommittee on Health and the Committee on Ways and Means of the U.S. House of Representatives.

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